

HMIS Intake Form for ES/TH/SO/SSO projects

Effective 10/01/2023

Intake Date	Entry Date	ServicePoint (HoH) ID:
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

Project Name

HoH Name First	Middle	Last
Suffix	Alias	
Name Data Quality		
<input type="checkbox"/> Full Name Reported	<input type="checkbox"/> Partial, Street or Code Name	
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer	
Social Security Number	Date of Birth	
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
<input type="checkbox"/> Full SSN Reported (HUD)	<input type="checkbox"/> Full DOB Reported (HUD)	
<input type="checkbox"/> Approx or partial SSN reported (HUD)	<input type="checkbox"/> Approx or partial SSN reported (HUD)	
<input type="checkbox"/> Client doesn't know (HUD)	<input type="checkbox"/> Client doesn't know (HUD)	
<input type="checkbox"/> Client prefers not to answer (HUD)	<input type="checkbox"/> Client prefers not to answer (HUD)	
<input type="checkbox"/> Data Not collected (HUD)	<input type="checkbox"/> Data Not collected (HUD)	
Race and Ethnicity (Select all that apply)		
<input type="checkbox"/> American Indian, Alaska Native, or Indigenous	<input type="checkbox"/> Native Hawaiian or Pacific Islander	
<input type="checkbox"/> Asian or Asian American	<input type="checkbox"/> White	
<input type="checkbox"/> Black, African American, or African	<input type="checkbox"/> Client doesn't know	
<input type="checkbox"/> Hispanic/Latina/e/o	<input type="checkbox"/> Client prefers not to answer	
<input type="checkbox"/> Middle Eastern or North African		
<input type="checkbox"/> Additional Race and Ethnicity detail: _____		
Gender (Select all that apply)		
<input type="checkbox"/> Woman (Girl, if child)	<input type="checkbox"/> Questioning	
<input type="checkbox"/> Man (Boy, if child)	<input type="checkbox"/> Different Identity	
<input type="checkbox"/> Culturally Specific Identity (e.g., Two-Spirit)	<input type="checkbox"/> Client doesn't know	
<input type="checkbox"/> Transgender	<input type="checkbox"/> Client prefers not to answer	
<input type="checkbox"/> Non-Binary		
<input type="checkbox"/> If Different Identity, Please Specify: _____		

Veteran Status	Relationship to HoH
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Self (Head of Household)
	<input type="checkbox"/> HoH's child <input type="checkbox"/> HoH's spouse or partner
	<input type="checkbox"/> HoH's other relation member <input type="checkbox"/> Other: non-relation member

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Date of Engagement – Street Outreach Only

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Health Insurance

- | | |
|--|---|
| <input type="checkbox"/> No | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Yes (identify source below) | <input type="checkbox"/> Client prefers not to answer |

Source

- | | |
|--|--|
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Medicare |
| <input type="checkbox"/> State Children's Health Insurance (KCHIP) | <input type="checkbox"/> Veteran's Health Administration (VHA) |
| <input type="checkbox"/> Employer-Provided Health Insurance | <input type="checkbox"/> Health Insurance obtained through COBRA |
| <input type="checkbox"/> Private Pay Health Insurance | <input type="checkbox"/> State Health Insurance for Adults |
| <input type="checkbox"/> Indian Health Services Program | <input type="checkbox"/> Other: |

Disability

Do you have a physical, mental or emotional impairment, a post-traumatic stress disorder, or brain injury; a development disability, HIV/AIDS, or a diagnosable substance abuse problem?

- | | | | |
|-----------------------------|---|--|---|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes (indicate type(s) below) | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Client prefers not to answer |
|-----------------------------|---|--|---|

	Physical <input type="checkbox"/>	Mental Health <input type="checkbox"/>	Chronic Health Condition <input type="checkbox"/>	<input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs <input type="checkbox"/> Both	Developmental <input type="checkbox"/>	HIV/AIDS <input type="checkbox"/>
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Foster Care

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

Zip Code of Last Permanent Address

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Client's Prior Living Situation - Prior to Project Entry				
(Select one Living Situation and answer the corresponding questions in the order in which they appear)				
Homeless Situations	Institutional Situations	Temporary Housing Situations	Permanent Housing Situation	Other
<input type="checkbox"/> Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher, Host Home shelter <input type="checkbox"/> Safe Haven	<input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail, prison or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center	<input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Staying or living in a friend's room, apartment, or house <input type="checkbox"/> Staying or living in a family member's room, apartment, or house	<input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with ongoing housing subsidy <ul style="list-style-type: none"> <input type="checkbox"/> GPD TIP housing subsidy <input type="checkbox"/> VASH housing subsidy <input type="checkbox"/> RRH or equivalent subsidy <input type="checkbox"/> HCV voucher (tenant or project based) (not dedicated) <input type="checkbox"/> Public housing unit <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Emergency Housing Voucher <input type="checkbox"/> Family Unification Program Voucher (FUP) <input type="checkbox"/> Foster Youth to Independence Initiative (FYI) <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Other permanent housing dedicated for formerly homeless persons <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy	<input type="checkbox"/> Other <input type="checkbox"/> Worker unable to determine <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
Length of Stay in Prior Living Situation (i.e. the literally homeless situation identified above)? <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more but less than one month <input type="checkbox"/> One month or more but less than 90 days <input type="checkbox"/> 90 days or more but less than one year <input type="checkbox"/> One year or longer	Length of Stay in Prior Living Situation (i.e. the institutional situation identified above)? <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more but less than one month <input type="checkbox"/> One month or more but less than 90 days <input type="checkbox"/> 90 days or more but less than one year <input type="checkbox"/> One year or longer Did you stay in the institutional situation less than 90 days? <input type="checkbox"/> Yes (If YES – Complete SECTION III) <input type="checkbox"/> No (If NO – End Homeless History Interview)	Length of Stay in Prior Living Situation (i.e. the housing situation identified above)? <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more but less than one month <input type="checkbox"/> One month or more but less than 90 days <input type="checkbox"/> 90 days or more but less than one year <input type="checkbox"/> One year or longer Did you stay in the housing situation less than 7 nights? <input type="checkbox"/> Yes (If YES – Complete SECTION III) <input type="checkbox"/> No (If NO – End Homeless History Interview)	Length of Stay in Prior Living Situation (i.e. the housing situation identified above)? <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more but less than one month <input type="checkbox"/> One month or more but less than 90 days <input type="checkbox"/> 90 days or more but less than one year <input type="checkbox"/> One year or longer Did you stay in the housing situation less than 7 nights? <input type="checkbox"/> Yes (If YES – Complete SECTION III) <input type="checkbox"/> No (If NO – End Homeless History Interview)	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> N/A (Complete SECTION IV Below)	On the <u>night before</u> entering the institutional situation did you stay on the streets, in emergency shelter or a safe haven? <input type="checkbox"/> Yes (If YES – Complete SECTION IV) <input type="checkbox"/> No (If NO – End Homeless History Interview)	On the <u>night before</u> entering the housing situation did you stay on the streets, in emergency shelter or a safe haven? <input type="checkbox"/> Yes (If YES – Complete SECTION IV) <input type="checkbox"/> No (If NO – End Homeless History Interview)	On the <u>night before</u> entering the housing situation did you stay on the streets, in emergency shelter or a safe haven? <input type="checkbox"/> Yes (If YES – Complete SECTION IV) <input type="checkbox"/> No (If NO – End Homeless History Interview)	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer

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On the night <u>before your previous stay</u> , was that on the streets, in an Emergency Shelter, or Safe Haven? <input type="checkbox"/> No <input type="checkbox"/> Yes	Approximate date this episode of homelessness started: <div style="border: 1px solid black; width: 150px; height: 20px; margin: 5px 0;"></div>
Total <u>number of times homeless</u> on the street, in ES, or SH in the past three years <input type="checkbox"/> One time <input type="checkbox"/> Two times <input type="checkbox"/> Three times <input type="checkbox"/> Four times <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	Total <u>number of months homeless</u> on the street, in emergency shelter, or SH in the past three years <div style="border-bottom: 1px solid black; width: 100px; margin-top: 5px;"></div>

Are you, or have you been a survivor of domestic or intimate partner violence?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
If YES, how long ago did you have this experience?	<input type="checkbox"/> Within the past three months <input type="checkbox"/> Three to six months ago <input type="checkbox"/> From six to twelve months ago <input type="checkbox"/> More than a year ago <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
If Yes, are you currently fleeing?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer



****IF CLIENT IS A MINOR WHO IS NOT HEAD OF HOUSEHOLD STOP DATA ENTRY HERE****

Income	
<input type="checkbox"/> No/None at all <input type="checkbox"/> Yes (identify source and amounts) <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	
Source	Amount:
<input type="checkbox"/> Earned income (i.e., employment income)	\$____. 00
<input type="checkbox"/> Unemployment Insurance	\$____. 00
<input type="checkbox"/> Supplemental Security Income (SSI)	\$____. 00
<input type="checkbox"/> Social Security Disability Income (SSDI)	\$____. 00
<input type="checkbox"/> Retirement Income from Social Security	\$____. 00
<input type="checkbox"/> VA Service-Connected Disability Compensation	\$____. 00
<input type="checkbox"/> VA Non-Service-Connected Disability Pension	\$____. 00
<input type="checkbox"/> Worker's Compensation	\$____. 00
<input type="checkbox"/> Temporary Assistance for Needy Families (TANF)	\$____. 00
<input type="checkbox"/> General Assistance (GA)	\$____. 00
<input type="checkbox"/> Private disability Insurance	\$____. 00
<input type="checkbox"/> Pension or retirement income from a former job	\$____. 00
<input type="checkbox"/> Child Support	\$____. 00
<input type="checkbox"/> Alimony or other spousal support	\$____. 00
<input type="checkbox"/> Other source: _____	\$____. 00
Total Monthly Income:	\$

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Non-Cash Benefits	
<input type="checkbox"/> No/None at all	<input type="checkbox"/> Yes (Identify source below)
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
Source	
<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP)	
<input type="checkbox"/> Special Supplemental, Nutrition Program for Women, Infants, and Children (WIC)	
<input type="checkbox"/> TANF Child Care services	
<input type="checkbox"/> TANF transportation services	
<input type="checkbox"/> Other TANF-funded services	
<input type="checkbox"/> Other: _____	

Client Contact Information

Client Phone Number	
Alt. Client Phone Number	
Email address/other electronic communication	
Mailing Address	
Translation Assistance Needed	
<input type="checkbox"/> No	<input type="checkbox"/> Yes (identify preferred language(s))
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
Preferred Language(s)	
<input type="checkbox"/> Amharic	<input type="checkbox"/> Marathi
<input type="checkbox"/> Arabic	<input type="checkbox"/> Nepali
<input type="checkbox"/> Bosnian	<input type="checkbox"/> Pashto
<input type="checkbox"/> Burmese	<input type="checkbox"/> Portuguese
<input type="checkbox"/> Cambodian	<input type="checkbox"/> Russian
<input type="checkbox"/> Chinese	<input type="checkbox"/> Samoan
<input type="checkbox"/> Croatian	<input type="checkbox"/> Serbian
<input type="checkbox"/> Dari	<input type="checkbox"/> Somali
<input type="checkbox"/> English	<input type="checkbox"/> Spanish
<input type="checkbox"/> French	<input type="checkbox"/> Swahili
<input type="checkbox"/> German	<input type="checkbox"/> Tamil
<input type="checkbox"/> Gujarati	<input type="checkbox"/> Telugu
<input type="checkbox"/> Haitian Creole	<input type="checkbox"/> Ukrainian
<input type="checkbox"/> Hawaiian	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Hindi	<input type="checkbox"/> Wolof
<input type="checkbox"/> Ilocano	<input type="checkbox"/> Yiddish
<input type="checkbox"/> Japanese	<input type="checkbox"/> Different Preferred Language
<input type="checkbox"/> Karen	<input type="checkbox"/> Client Doesn't Know
<input type="checkbox"/> Kinyarwanda	<input type="checkbox"/> Client Prefers Not to Answer
<input type="checkbox"/> Korean	<input type="checkbox"/> Data Not Collected
<input type="checkbox"/> Lingala	
<input type="checkbox"/> Luganda	
<input type="checkbox"/> Mandarin	
If Different Preferred Language, please specify	

Staff Completing (Printed Name):

Date: