

HMIS Intake and Enrollment Form CoC/ESG/HP/RRH

Client ID: _____

Staff Completing HMIS Form: _____

Identification - All fields required unless otherwise noted

Completed HMIS Consent Form	No (Refused)	Signed
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First Name _____ **Middle Name** _____

Last Name _____ **Suffix** _____

Name Data Quality: Did the client provide their full name?	Social Security Number (SSN)	Birth Date (DOB)
<input type="checkbox"/> Full Name Reported <input type="checkbox"/> Partial, street name, or code name reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	_____ - _____ - _____ <input type="checkbox"/> Full SSN reported <input type="checkbox"/> Approximate or partial SSN reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	____/____/_____ <input type="checkbox"/> Approximate or partial DOB reported <input type="checkbox"/> Full DOB reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Basic Demographics – All fields required unless otherwise noted

Gender	Race (Check all that apply)
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans Female (Male to Female) <input type="checkbox"/> Trans Male (Female to Male) <input type="checkbox"/> Gender Non-Conforming (Not exclusively male or Female) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Relationship to Head of Household	Ethnicity
<input type="checkbox"/> Self <input type="checkbox"/> Head of Household's Child <input type="checkbox"/> Head of Household's Spouse or Partner <input type="checkbox"/> Head of Household's other Relation Member (Other relation to head of household) <input type="checkbox"/> Other: Non-relation Member	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/ Non-Latino <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Veteran (Have you ever served in the U.S. Military?)
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Housing Move in Date(All PH - HOH ONLY)	Disabling Condition
____/____/_____ _____/_____/_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Program Name: _____ :

Case Manager: _____

Program Start Date _____

****Data Assessment for Living Situation: (FOR ALL PERSONS ENTERING EMERGENCY SHELTER, SAFE HAVEN, AND STREET OUTREACH) go to page 2**

****Data Assessment for Living Situation: (FOR ALL PERSONS ENTERING ALL OTHER PROJECTS EXCEPT EMERGENCY SHELTER, SAFE HAVEN, AND STREET OUTREACH) go to page 3**

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Universal Data Assessment		
Client Location: CA-510 – Turlock/ Modesto/ Stanislaus County CoC		
Living Situation: (FOR ALL PERSONS ENTERING EMERGENCY SHELTER, SAFE HAVEN, AND STREET OUTREACH)		
Question	Check One Answer	
1. What was the situation you were living in immediately prior to project entry? (Type of residence)	<input type="checkbox"/> Place not meant for habitation <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter <input type="checkbox"/> Safe Haven <input type="checkbox"/> Interim Housing <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"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Permanent housing (Other than RRH) for formerly homeless persons <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with VASH subsidy <input type="checkbox"/> Rental by client, with GPD TIP subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy (Including RRH) <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> Staying or living in a friend's room, apartment or house <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	
2. How long was the client staying in that place? (Length of stay in prior living situation)	<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 <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
3. What approximate date did you start living on the streets, emergency shelter, or safe haven? (Approximate date started)	_____/_____/_____	
Regardless of where they stayed last night number of times the client has been on the streets, in ES, or SH in the past three years including today	<input type="checkbox"/> One Time <input type="checkbox"/> Two Times <input type="checkbox"/> Three Times	<input type="checkbox"/> Four or more times <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Total Number of months homeless on the streets, in ES, or SH in the past three years	<input type="checkbox"/> One Month (this time is the first month) <input type="checkbox"/> 2-12 (____ months)	<input type="checkbox"/> More than 12 <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

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Universal Data Assessment		
Living Situation: (FOR ALL PROJECTS EXCEPT EMERGENCY SHELTER, SAFE HAVEN, AND STREET OUTREACH)		
<p>1. What was the living Situation you were living in immediately prior to project entry? <i>Literally Homeless Situations</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Place not meant for habitation <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter <input type="checkbox"/> Safe Haven <input type="checkbox"/> Interim Housing 	<p>2. Length of stay in prior living situation? <i>For literally homeless situations:</i></p> <ul style="list-style-type: none"> <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 <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused 	<p>3. Did the Client stay less than... Not Applicable (Continue to questions 5-7)</p>
<p>1. What was the living Situation you were living in immediately prior to project entry? <i>Institutional Situations</i></p> <ul style="list-style-type: none"> <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 	<p>2. Did you stay less than... 90 Days</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes (Answer 3-4) <input type="checkbox"/> No (Enter Wellness Assessment) 	<p>3. Length of stay in prior living situation? <i>For institutional situations:</i></p> <ul style="list-style-type: none"> <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 <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
<p>1. What was the living Situation you were living in immediately prior to project entry? <i>Transitional & Permanent Housing Situations</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Permanent housing (Other than RRH) for formerly homeless persons <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with VASH subsidy <input type="checkbox"/> Rental by client, with GPD TIP subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy (Including RRH) <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> Staying or living in a friend's room, apartment or house <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) 	<p>2. Did you stay less than... 7 Nights</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes (Answer 3-7) <input type="checkbox"/> No (Answer 3 then continue to Wellness Assessment) 	<p>3. Length of stay in prior living situation? <i>Transitional & Permanent Housing Situations</i></p> <ul style="list-style-type: none"> <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 <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused

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4. On the night before your current housing situation did you stay on the street, Emergency Shelter, or Safe Haven	<input type="checkbox"/> Yes(Continue to questions 5-7) <input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> No (Continue with Wellness Assessment) <input type="checkbox"/> Client Refused
5. When did the client start staying on the streets, in emergency shelters, or in the safe havens this time?	_____ / _____ / _____	
6. How many times has the client been homeless on the streets, in shelters in the past 3 years?	<input type="checkbox"/> One Time <input type="checkbox"/> Two Times <input type="checkbox"/> Three Times	<input type="checkbox"/> Four or more times <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
7. How many months, in total, have the client has been homeless on the street, in an emergency shelter, or Safe Haven over the past three years?	<input type="checkbox"/> One Month (this time is the first month) <input type="checkbox"/> 2-12 (_____ months)	<input type="checkbox"/> More than 12 <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Wellness Assessment

Health Insurance

Yes (Enter the Source)
 No
 Client Doesn't Know
 Client Refused

Health Insurance Sources

- Private Pay Health Insurance
- Medicare
- MEDICAID
- State Children's Health Insurance(SCHIP)
- VA Medical Services
- Employer Provided Health Insurance
- Health Insurance obtained through COBRA
- State Health Insurance Adults (Medi-cal)
- Indian Health Services Program

Other: _____

Barriers:

	Barrier Present	Condition is Indefinite
Alcohol Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
Chronic Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
Development Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
Mental health	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
Physical Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused

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Domestic Violence	
Is the client a domestic violence victim/survivor?	<input type="checkbox"/> Yes (Answer questions below) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
If yes, How long ago did you have this experience?	<input type="checkbox"/> Within the past 3 months <input type="checkbox"/> 3 months to 6 months ago <input type="checkbox"/> 6 months to one year <input type="checkbox"/> One year ago or more <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
If yes are you currently Fleeing?	<input type="checkbox"/> Yes (Answer questions below) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Financial Assessment

Check all that Apply and Enter amount

Income Source (Check all that apply)	Stated Income	Non-Cash Resources (Check all that apply)	Stated Amounts
<input type="checkbox"/> Yes (Check all Sources that Apply) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		<input type="checkbox"/> Yes (Check all Sources that Apply) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
<input type="checkbox"/> Earned Income (<i>employment wages / cash</i>)	\$	<input type="checkbox"/> Special Supplemental nutritional Program Women and Children	\$
<input type="checkbox"/> Unemployment Insurance	\$	<input type="checkbox"/> Food Stamps (CalFresh) SNAP	\$
<input type="checkbox"/> Supplemental Security Income (SSI)	\$	<input type="checkbox"/> CalWorks Child Care/TANF Child Care Services	\$
<input type="checkbox"/> Social Security Disability Income (SSDI)	\$	<input type="checkbox"/> CalWorks Transportation (TANF)	
<input type="checkbox"/> VA Service-Connected Disability Compensation	\$	<input type="checkbox"/> Other CalWorks-Funded Services (TANF)	\$
<input type="checkbox"/> VA Non-Service-Connected Disability Pension	\$	<input type="checkbox"/> Other	\$
<input type="checkbox"/> Private Disability Insurance	\$		
<input type="checkbox"/> Workers Compensation	\$		
<input type="checkbox"/> Pension or Retirement income from a job	\$		
<input type="checkbox"/> TANF	\$		
<input type="checkbox"/> General Assistance	\$		
<input type="checkbox"/> Retirement (Social Security)	\$		
<input type="checkbox"/> Child Support	\$		
<input type="checkbox"/> Alimony or other Spousal Support	\$		
<input type="checkbox"/> Other Income	\$		