# HMIS Intake and Enrollment Form CoC/ESG/Private Funded:

*For persons entering HMIS project type:* ***Transitional Housing, any type of Permanent Housing/RRH, Services Only, Homeless Prevention***

Client ID: ____________________

Project Name: ____________________

Staff Completing HMIS Form: ____________________

***Identification*** *- All fields required unless otherwise noted*

| Completed HMIS Consent Form | | No (Refused) | | Signed |
|---|---|---|---|---|

**First Name** ______________________ **Middle Name** ______________________

**Last Name** **Suffix**

| **Name Data Quality:** Did the client provide their full name? | **Social Security Number (SSN)** | **Birth Date (DOB)** |
|---|---|---|
| □ Full Name Reported<br>□ Partial, street name, or code name reported<br>□ Client Doesn't Know<br>□ Client Refused | _______-______-________<br>□ Full SSN reported<br>□ Approximate or partial SSN reported<br>□ Client Doesn't Know<br>□ Client Refused | ______/______/_________<br>□ Approximate or partial DOB Reported<br>□ Full DOB reported<br>□ Client Doesn't Know<br>□ Client Refused |

**Basic Demographics – All fields required unless otherwise noted**

| **Race (Check all that apply)** | **Ethnicity** |
|---|---|
| □ American Indian or Alaska Native<br>□ Asian<br>□ Black or African American<br>□ Native Hawaiian or Other Pacific Islander<br>□ White<br>□ Client Doesn't Know<br>□ Client Refused | □ Hispanic/Latino<br>□ Non-Hispanic/ Non-Latino<br>□ Client Doesn't Know<br>□ Client Refused |
| **Gender** | **Relationship to Head of Household** |
| □ Male<br>□ Female<br>□ Trans Male (Female to Male)<br>□ Trans Female (Male to Female)<br>□ Gender Non-Conforming (Not exclusively Male or Female)<br>□ Client Doesn't Know<br>□ Client Refused | □ Self<br>□ Son<br>□ Daughter<br>□ Dependent Child<br>□ Spouse<br>□ Other: Family Member<br>□ Other: Non-Family Member |
| | **Name of Head of Household**<br>______________________________________________ |
| | **Veteran** (Have you ever served in the U.S. Military?)<br>□ Yes □ No □ Client Doesn't Know □ Client Refused |
| | **Disabling Condition**<br>□ Yes □ No □ Client Doesn't Know □ Client Refused |

| **Project Start Date** | ______/______/________ |
|---|---|
| **Housing Move in Date (All PH/RRH HOH Only)** | ______/______/________ |

## Universal Data Assessment

**Living Situation: Identify the type of residence and length of stay at that residence just prior to (i.e., program admission)**

***Literally Homeless Situations***

**1. What was the living Situation you were living in immediately prior to project entry?**

- ☐ Place not meant for habitation
- ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher or RHY funded Host Home shelter
- ☐ Safe Haven

**2. Length of stay in prior living situation?**

- ☐ One night or less
- ☐ Two to six nights
- ☐ One week or more, but less than one month
- ☐ One month or more, but less than 90 days
- ☐ 90 days or more, but less than one year
- ☐ One year or longer
- ☐ Client doesn't know
- ☐ Client refused

**3. What approximate date did you start living on the streets, emergency shelter, or safe haven? *(Approximate date homelessness started)***

_______/_________/___________

**4. 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?**

- ☐ One Time
- ☐ Two Times
- ☐ Three Times
- ☐ Four or more times
- ☐ Client Doesn't Know
- ☐ Client Refused

**5. Total number of months homeless on the streets, in ES, or SH in the past three years?**

- ☐ One Month (this time is the first month)
- ☐ 2-12 (_____ months)
- ☐ More than 12
- ☐ Client Doesn't Know
- ☐ Client Refused

***Institutional Situations***

**1. What was the living Situation you were living in immediately prior to project entry?**

- ☐ Foster care home or foster care group home
- ☐ Hospital or other residential non-psychiatric medical facility
- ☐ Jail, prison or juvenile detention facility
- ☐ Long-term care facility or nursing home
- ☐ Psychiatric hospital or other psychiatric facility
- ☐ Substance abuse treatment facility or detox center

**2. Did you stay less than 90 Days**

- ☐ Yes (Continue to questions 3-4)
- ☐ No ( Continue to question 3 and then Enter Wellness Assessment)

**3. Length of stay in prior living Situation?**

- ☐ One night or less
- ☐ Two to six nights
- ☐ One week or more, but less than one month
- ☐ One month or more, but less than 90 days
- ☐ 90 days or more, but less than one year
- ☐ One year or longer
- ☐ Client doesn't know
- ☐ Client refused

**4. On the night before did you stay on the street, Emergency Shelter, or Safe Haven**

- ☐ Yes(Continue to questions 5-7)
- ☐ Client Doesn't Know
- ☐ No (Continue with Wellness Assessment)
- ☐ Client Refused

**5. What approximate date did you start living on the streets, emergency shelter, or safe haven? *(Approximate date homelessness started)***

_______/_________/___________

**6. 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?**

- ☐ One Time
- ☐ Two Times
- ☐ Three Times
- ☐ Four or more times
- ☐ Client Doesn't Know
- ☐ Client Refused

**7. Total number of months homeless on the streets, in ES, or SH in the past three years?**

- ☐ One Month (this time is the first month)
- ☐ 2-12 (_____ months)
- ☐ More than 12
- ☐ Client Doesn't Know
- ☐ Client Refused

***Transitional & Permanent Housing Situations***

**1. What was the living Situation you were living in immediately prior to project entry?**

- ◻ Residential project or halfway house with no homeless criteria
- ◻ Hotel or motel paid for without emergency shelter voucher
- ◻ Rental by client, with VASH housing subsidy
- ◻ Transitional housing for homeless persons (including homeless youth)
- ◻ Host Home (non-crisis)
- ◻ Staying or living in a friend's room, apartment or house
- ◻ Staying or living in a family member's room, apartment or house
- ◻ Rental by client, with GPD TIP subsidy
- ◻ Permanent housing (Other than RRH) for formerly homeless persons
- ◻ Rental by client, with RRH or equivalent subsidy
- ◻ Rental by client, with HCV voucher (tenant or project based)
- ◻ Rental by client, in a public housing unit
- ◻ Rental by client, no ongoing housing subsidy
- ◻ Rental by client, with other ongoing housing subsidy
- ◻ Owned by client, with ongoing housing subsidy
- ◻ Owned by client, no ongoing housing subsidy
- ◻ Client Doesn't Know
- ◻ Client Refused

**2. Did you stay less than 7 Nights**

- ◻ Yes (Continue to questions 3-4)
- ◻ No (Answer 3 then continue to Wellness Assessment)

**3. Length of stay in prior living Situation?**

- ◻ One night or less
- ◻ Two to six nights
- ◻ One week or more, but less than one month
- ◻ One month or more, but less than 90 days
- ◻ 90 days or more, but less than one year
- ◻ One year or longer
- ◻ Client doesn't know
- ◻ Client refused

**4. On the night before did you stay on the street, Emergency Shelter, or Safe Haven**

◻ Yes(Continue to questions 5-7) ◻ No (Continue with Wellness Assessment)
◻ Client Doesn't Know ◻ Client Refused

**5. What approximate date did you start living on the streets, emergency shelter, or safe haven? *(Approximate date homelessness started)***

_______/_________/___________

**6. How many times has the client been homeless on the streets, in shelters in the past 3 years?**

◻ One Time ◻ Four or more times
◻ Two Times ◻ Client Doesn't Know
◻ Three Times ◻ Client Refused

**7. Total number of months homeless on the streets, in ES, or SH in the past three years**

◻ One Month (this time is the first month) ◻ More than 12
◻ 2-12 (_____ months) ◻ Client Doesn't Know
◻ Client Refused

## Wellness Assessment

### Health Insurance

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

**Health Insurance Sources**

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

| Barriers: | | |
|---|---|---|
| | **Barrier Present** | **Condition is Indefinite** |
| Alcohol Abuse | □ Yes □ No □ Don't Know □ Client Refused | □ Yes □ No □ Don't Know □ Client Refused |
| Chronic Health Condition | □ Yes □ No □ Don't Know □ Client Refused | □ Yes □ No □ Don't Know □ Client Refused |
| Developmental Disability | □ Yes □ No □ Don't Know □ Client Refused | |
| Drug Abuse | □ Yes □ No □ Don't Know □ Client Refused | □ Yes □ No □ Don't Know □ Client Refused |
| HIV/AIDS | □ Yes □ No □ Don't Know □ Client Refused | |
| Mental health | □ Yes □ No □ Don't Know □ Client Refused | □ Yes □ No □ Don't Know □ Client Refused |
| Physical Disability | □ Yes □ No □ Don't Know □ Client Refused | □ Yes □ No □ Don't Know □ Client Refused |

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

**Financial Assessment**

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

| **Pets –** *Please indicate pets and the number* | **City and State where you first became homeless?** |
|---|---|
| □ Yes (If yes, answer below) □ No<br>□ Dog #_____ □ Cats #_____ □ Other _____ #____ | ________________________________, ______________<br>City State |