

HMIS Intake and Enrollment Form RHY

For persons entering HMIS project type: **RHY**

Client ID: _____

Project Name: _____

Staff Completing HMIS form _____

Identification - All fields required unless otherwise noted

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

Race (Check all that apply)	Ethnicity
<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	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/ Non-Latino <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Gender	Pregnancy Status (All Females)
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans Male (Female to Male) <input type="checkbox"/> Trans Female (Male to Female) <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"/> Yes* (Due Date _____) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
	Veteran (Have you ever served in the U.S. Military?) 18 and over <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Relationship to Head of Household	Project Start Date
<input type="checkbox"/> Self <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Dependent Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other: Family Member <input type="checkbox"/> Other: Non-Family Member	_____ / _____ / _____ Disabling Condition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Universal Data Assessment

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

- 1. What was the situation you were living in immediately prior to project entry? (The night before)**
- 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
 - 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
 - Residential project or halfway house with no homeless criteria
 - Hotel or motel paid for without emergency shelter voucher
 - Rental by client, with VASH 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, with 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. 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

Universal Data Assessment

Living Situation: PATHWAYS 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

6. 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
- Data Not Collected

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

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

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

- Yes(Continue to questions 5-7)
- Client Doesn't Know

- No (Continue with Wellness Assessment)
- Client Refused

_____/_____/_____

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

- 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

Health Insurance

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

Health Insurance Sources

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Private Pay Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> MEDICAID <input type="checkbox"/> State Children's Health Insurance (SCHIP) <input type="checkbox"/> VA Medical Services <input type="checkbox"/> Employer Provided Health Insurance | <ul style="list-style-type: none"> <input type="checkbox"/> Health Insurance obtained through COBRA <input type="checkbox"/> State Health Insurance Adults (Medi-Cal) <input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Other: _____ |
|---|---|

BCP Status: (BCP Only)	Yes (select options below)	No (Reason why services are not funded by BCP Grant)	
Date of Determination: ____/____/____ Youth eligible for RHY services? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is youth a runaway? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Out of age range <input type="checkbox"/> Ward of the State (Immediate Reunification) <input type="checkbox"/> Ward of the Criminal Justice System (Immediate Reunification) <input type="checkbox"/> 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	
Developmental Disability	<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		
Mental Illness	<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	
Domestic Violence (TLP Only)			
Is the client a domestic violence victim/survivor?	<input type="checkbox"/> Yes (Answer questions below) <input type="checkbox"/> No	<input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know	
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 <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
Financial Assessment			
Income Source <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	Stated Income (Monthly) Pathways only	Non-Cash Resources <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	Stated Amounts (Monthly)
<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"/> Private Disability Insurance	\$	<input type="checkbox"/> Other CalWorks-Funded Services (TANF)	\$
<input type="checkbox"/> Workers Compensation	\$	<input type="checkbox"/> Other	\$
<input type="checkbox"/> VA Service-Connected Disability Compensation	\$		
<input type="checkbox"/> VA Non-Service-Connected Disability Pension	\$		
<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	\$		

Employment Assessment			
<input type="checkbox"/> Yes (Complete Information Below)	<input type="checkbox"/> No(Complete Information Below)		
<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused		
If Yes-Type of Employment	<input type="checkbox"/> Full-time	<input type="checkbox"/> Part-Time	<input type="checkbox"/> Seasonal/Sporadic (including day labor)
If No Why not employed?	<input type="checkbox"/> Looking for work	<input type="checkbox"/> Unable to work	<input type="checkbox"/> Not Looking for work
Educational Assessment		Post-Secondary Options	
Highest Grade Completed	<input type="checkbox"/> No School Completed <input type="checkbox"/> School program does not have a grade level <input type="checkbox"/> Nursery School to 4 th <input type="checkbox"/> 5 th or 6 th grade <input type="checkbox"/> 7 th or 8 th grade <input type="checkbox"/> 9 th grade	<input type="checkbox"/> 10 th grade <input type="checkbox"/> 11 th grade <input type="checkbox"/> 12 th grade, No Diploma <input type="checkbox"/> High School Diploma <input type="checkbox"/> GED <input type="checkbox"/> Post-Secondary (Fill-in level) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Associates Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree <input type="checkbox"/> Doctorate Degree <input type="checkbox"/> Other Graduate/Professional degree <input type="checkbox"/> Vocational certification/ Certificate of advanced training or skilled artisan
School Status	<input type="checkbox"/> Attending school regularly <input type="checkbox"/> Attending School irregularly <input type="checkbox"/> Graduated high school	<input type="checkbox"/> Obtained GED <input type="checkbox"/> Suspended <input type="checkbox"/> Expelled	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Dropped out
Health Assessment			
General Health Status	<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Dental Health Status	<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Mental Health Status	<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Sexual Orientation			
<input type="checkbox"/> Heterosexual <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Bi-sexual	<input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Other: _____ (please describe) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		
RHY Entry Assessment			
Referral Resources			
<input type="checkbox"/> Self-Referral <input type="checkbox"/> Individual/Parent/Guardian/Relative /Friend/Foster Parent/Other Individual <input type="checkbox"/> Outreach Project Number of times approached by Outreach prior to entering the project? _____	<input type="checkbox"/> Temporary Shelter <input type="checkbox"/> Residential Shelter <input type="checkbox"/> Hotline <input type="checkbox"/> Child Welfare/CPS	<input type="checkbox"/> Juvenile Justice <input type="checkbox"/> Law Enforcement/Police <input type="checkbox"/> Mental Hospital	<input type="checkbox"/> School <input type="checkbox"/> Other Organization <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Family Critical Issue			Status
Unemployment - Family member			<input type="checkbox"/> Yes <input type="checkbox"/> No
Mental Health Issues- Family member			<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Disability –Family member			<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcohol or Substance Abuse –Family member			<input type="checkbox"/> Yes <input type="checkbox"/> No
Insufficient Income to support youth - Family member			<input type="checkbox"/> Yes <input type="checkbox"/> No
Incarcerated Parent of Youth			<input type="checkbox"/> Yes <input type="checkbox"/> No
Formally a Ward of :			
System		Number of Years	If less than a year (Number of Months)
Juvenile Justice System	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Less than one year <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 3 to 5 years	
Child Welfare/Foster Care Agency	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Less than one year <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 3 to 5 years	