HMIS Intake and Enrollment Form
CoC/ESG/State & Private Funded

For persons entering HMIS project type: Emergency Shelter

Client ID: _____
Project Name: _____
Staff Name: _____

Returning Clients: Where did you go/stay when you left the last time you were here?
_____

Identification-*All fields required unless otherwise noted*

First Name: _____ **Middle Name:** _____

Last Name: _____ **Suffix:** _____

Name Data Quality: Did the client provide their full name?

☐Full Name Reported ☐Partial, street name, or code name reported
☐Client doesn't know ☐Client prefers not to answer

Social Security Number (SSN): _____-_____-_____

☐Full SSN reported ☐Approximate or parial SSN reported
☐Client doesn't know ☐Client prefers not to answer

Birth Date (DOB): _____/_____/_____

☐Approximate or partial DOB reported ☐Full DOB reported
☐Client doesn't know ☐Client prefers not to anser

Basic Demographics-*All fields required unless otherwise noted*

Race and Ethnicity *(Check all that apply)*

☐American Indian, Alaska Native, or Indigenous ☐Asian or Asian American
☐Black, African American, or African ☐Hispanic/Latina/o
☐Middle Eastern or North African ☐Native Hawaiian or Pacific Islander
☐White
☐Client doesn't know
☐Client prefers not to answer

Sex

☐Female
☐Male
☐Client doesn't know
☐Client prefers not to answer

Veteran Status *(Have you ever served in the U.S. Military?)*

☐Yes ☐No ☐Client does not know ☐Client prefers not to answer

Mailing Address and Contact Information *(Includes, not limited to, service organizations, access centers, emergency shelter, transitional housing, client residence)*

Address: _____
City, State, Zip Code: _____
Email: _____
Main Phone: _____
Message Phone: _____

Name of Head of Household: _____

Relationship to Head of Household

☐Self ☐Son ☐Daughter ☐Dependent child ☐Spouse
☐Other Family Member ☐Other Non-Family Member

Project Start Date: ____/____/_____

Universal Data Assessment

Disabling Condition

☐Yes ☐No ☐Client does not know ☐Client prefers not to answer

Living Situation: *Identify the type of residence and length of stay at that residence just prior to program admission*

1. What was the situation you were living in immediately prior to project entry? (*The night before)*

Literally Homeless

☐Place not meant for habitation:
☐**Car/ Truck/Van** ☐ **RV** ☐**Other**
☐Emergency Shelter: including hotel or motel paid for with emergency shelter voucher or Host Home shelter
☐Safe Haven

Institutional Situations

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

Temporary Housing

☐Transitional Housing for homeless persons (including homeless youth)
☐Hotel or motel paid for without emergency shelter voucher
☐Staying or living in a family member's room, apartment, or house
☐Residential project or halfway house with no homeless criteria
☐Host Home (non-crisis)
☐Staying or living in a friend's room, apartment, or house

Permanent Housing

☐Rental by client, with no ongoing housing subsidy
☐Rental by client, with other ongoing housing subsidy
Subsidy Type:
☐GPD TIP housing subsidy
☐RRH or equivalent subsidy
☐Public Housing Unit
☐Emergency Housing Voucher
☐Foster Youth to Independence Initiative (FYI)
☐VASH housing subsidy
☐HCV voucher (tenant or project based) (not dedicated)
☐Rental by client, with other ongoing housing subsidy
☐Family Unification Program Voucher (FUP)
☐Permanent Supportive Housing
☐Other permanent housing dedicated for formerly homeless persons
☐Owned by client, with ongoing housing subsidy
☐Owned by client, no ongoing subsidy

☐Client doesn't know
☐Client prefers not to answer

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 prefers not to answer

3. Approximate date this episode of homelessness started: ____/____/_____

4. Regardless of where they stayed last night, number of times client has been on the streets, 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 prefers not to answer

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 (____ months)
☐More than 12 months
☐Client doesn't know
☐Client prefers not to answer

Health Insurance

☐Yes ☐No ☐Client does not know ☐Client prefers not to answer

Health Insurance Sources *(Check all that apply)*

☐Private Pay Health Insurance	☐Medicare
☐MEDICAID	☐Health Net (Medi-Cal)-Adults
☐Health Net (Medi-Cal)-Children	☐State Kaiser (Medi-Cal)-Adults
☐State Kaiser (Medi-Cal)-Children	☐Health Plan of San Joaquin (Medi-Cal)-Adults
☐Health Plan of San Joaquin (Medi-Cal)-Children	☐State Children's Health Insurance (Medi-Cal)
☐Veteran's Health Administration (VHA)	☐Employer Provided Health Insurance
☐Health Insurance obtained through COBRA	☐State Funded Insurance for Adults (Medi-Cal)
☐Indian Health Services Program (IHS)	☐Other: _____

Barriers *(Check all that apply)*

Is the barrier expected to be long-continued or of indefinite duration? Does it substantially impede the client's availability to live independently; and could be improved by the provision of suitable housing?

	Barrier Present	**Condition is indefinite**
☐Alcohol Disorder	☐Yes ☐No ☐Doesn't know ☐ Client prefers not to answer	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer
☐Chronic Health Condition	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer
☐Developmental Disability	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer	
☐Drug Use Disorder	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer
☐HIV/AIDS	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer	
☐Mental Health Disorder	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer
☐Physical Disability	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer

Domestic Violence Survivor

Domestic Violence Experience?

☐Yes *(Answer questions below)* ☐No ☐Client doesn't know ☐Client prefers not to answer

When experience occurred?

☐Within the past 3 months	☐3 months to 6 months ago *(excluding 6 mos exactly)*
☐6 months to one year ago *(excluding 1 year exactly)*	☐One year ago or more
☐Client doesn't know	☐Client prefers not to answer

If yes, are you currently fleeing?

☐Yes ☐No ☐Client doesn't know ☐Client prefers not to answer

Financial Assessment	
Does client have any source of Income? *(If Yes, check all that apply)*	
☐Yes ☐No ☐Client does not know ☐Client prefers not to answer	
Income Source	**Monthly Amount**
☐Earned Income (employment wages/cash)	$
☐Unemployment Insurance	$
☐Supplemental Security Income (SSI)	$
☐Social Security Disability Insurance (SSDI)	$
☐Private Disability Insurance	$
☐Workers Compensation	$
☐VA Service-Connected Disability Compensation	$
☐VA Non-Service Connected Disability Pension	$
☐Pension of Retirement Income from a job	$
☐TANF (CalWorks)	$
☐General Assistance	$
☐Retirement (Social Security)	$
☐Child Support	$
☐Alimony	$
☐Other Income	$
Does client have any Non-Cash Benefits? *(If Yes, check all that apply)*	
☐Yes ☐No ☐Client does not know ☐Client prefers not to answer	
Non-Cash Benefits	**Monthly Amount**
☐Special Supplemental Nutrition Program for Woman, Infants, and Children	$
☐Food Stamps (CalFresh) SNAP	$
☐CalWorks Child Care/TANF Child Care Services	$
☐CalWorks Transportation (TANF)	$
☐Other CalWorks-Funded Services (TANF)	$
☐Other Sources	$