

# HMIS Intake and Enrollment Form

## CoC/ESG/Private Funded

For persons entering HMIS project type: **Emergency Shelter**

Client ID: \_\_\_\_\_

Project Name: \_\_\_\_\_

Staff Completing HMIS Form: \_\_\_\_\_

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

**First Name** \_\_\_\_\_ **Middle Name** \_\_\_\_\_

**Last Name** \_\_\_\_\_ **Suffix** \_\_\_\_\_

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

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

#### **Ethnicity**

- Hispanic/Latino(a)(o)(x)** is a person of Central American, Latin American, or South American origin, separate from race.
- Non-Hispanic/ Non-Latino(a)(o)(x)** is a person NOT of Central American, Latin American, or South American origin, separate from race.
- Client Doesn't Know**
- Client Refused**

#### **Race (Check all that apply)**

- American Indian, Alaska Native, or Indigenous** is a person having origins to any of the indigenous peoples of North and South America, including Central America.
- Asian or Asian American** is a person having origins of Asian descent, including but not limited to Chinese, Indian, Japanese, Korean, Pakistani, Vietnamese, or another representative nation/region.
- Black, African American, or African** is a person having origins to any of the Black racial groups of Africa, including Afro-Caribbean.
- Native Hawaiian or Pacific Islander** is a person having origins in any of the indigenous peoples of Hawaii, Guam, Samoa, or another Pacific Island.
- White** is a person having origins in any of the original peoples of Europe, the Middle East or North Africa.
- Client Doesn't Know**
- Client Refused**

#### **Gender (Check all that apply)** **Client authorizes update in HMIS if gender is different?** Yes No

- Female** is a person who lives or identifies as female.
- Male** is a person who lives or identifies as male.
- A gender other than singularly female or male (e.g., non-binary, genderfluid, agender, culturally specific gender)** is a person who lives or identifies as a gender other than female, a gender other than male, a gender outside the binary, no gender, more than one gender, a culturally specific gender, or a gender that changes over time.
- Transgender** is a person who lives or identifies with a transgender history, experience, or identity.
- Questioning** is a person who may be unsure, may be exploring, or may not relate to or identify with a gender identity at this time.
- Client Doesn't Know**
- Client Refused**

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

**Name of Head of Household** \_\_\_\_\_

|  |  |  |   |
|--|--|--|---|
| <b>Relationship to Head of Household</b> | <input type="checkbox"/> Self<br><input type="checkbox"/> Son<br><input type="checkbox"/> Daughter | <input type="checkbox"/> Dependent Child<br><input type="checkbox"/> Spouse<br><input type="checkbox"/> Other: Family Member | <input type="checkbox"/> Other: Non-Family Member |
|--|--|--|---|

|                            |   |   |
|----------------------------|---|---|
| <b>Disabling Condition</b> | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Client Doesn't Know<br><input type="checkbox"/> Client Refused |
|----------------------------|---|---|

**Project Start Date** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

| Universal Data Assessment  |  |  |   |
|--|--|--|---|
| <b>Living Situation: Identify the type of residence and length of stay at that residence just prior to (i.e., program admission)</b>                           |  |  |   |
| <b>1. What was the situation you were living in immediately prior to project entry? (The night before)</b>   | <input type="checkbox"/> Place not meant for habitation<br><input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher or RHY funded Host Home shelter<br><input type="checkbox"/> Safe Haven<br><input type="checkbox"/> Foster care home or foster care group home<br><input type="checkbox"/> Hospital or other residential non-psychiatric medical facility<br><input type="checkbox"/> Jail, prison or juvenile detention facility<br><input type="checkbox"/> Long-term care facility or nursing home<br><input type="checkbox"/> Psychiatric hospital or other psychiatric facility<br><input type="checkbox"/> Substance abuse treatment facility or detox center<br><input type="checkbox"/> Residential project or halfway house with no homeless criteria<br><input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher<br><input type="checkbox"/> Rental by client, with VASH subsidy<br><input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) | <input type="checkbox"/> Host Home (non-crisis)<br><input type="checkbox"/> Staying or living in a family member's room, apartment or house<br><input type="checkbox"/> Staying or living in a friend's room, apartment or house<br><input type="checkbox"/> Rental by client, with GPD TIP subsidy<br><input type="checkbox"/> Permanent housing (Other than RRH) for formerly homeless persons<br><input type="checkbox"/> Rental by client, with RRH or equivalent subsidy<br><input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based)<br><input type="checkbox"/> Rental by client in a public housing unit<br><input type="checkbox"/> Rental by client, with no ongoing housing subsidy<br><input type="checkbox"/> Rental by client, with other ongoing housing subsidy<br><input type="checkbox"/> Owned by client, with ongoing housing subsidy<br><input type="checkbox"/> Owned by client, no ongoing housing subsidy<br><input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client refused |   |
| <b>2. Length of stay in prior living situation?</b>  | <input type="checkbox"/> One night or less<br><input type="checkbox"/> Two to six nights<br><input type="checkbox"/> One week or more, but less than one month<br><input type="checkbox"/> One month or more, but less than 90 days  | <input type="checkbox"/> 90 days or more, but less than one year<br><input type="checkbox"/> One year or longer<br><input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client refused   |   |
| <b>3. What approximate date did you start living on the streets, emergency shelter, or safe haven? (Approximate date homelessness started)</b>                 | _____ / _____ / _____  |  |   |
| <b>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?</b> | <input type="checkbox"/> One Time<br><input type="checkbox"/> Two Times<br><input type="checkbox"/> Three Times  | <input type="checkbox"/> Four or more times<br><input type="checkbox"/> Client Doesn't Know<br><input type="checkbox"/> Client Refused   |   |
| <b>5. Total Number of months homeless on the streets, in ES, or SH in the past three years?</b>  | <input type="checkbox"/> One Month (this time is the first month)<br><input type="checkbox"/> 2-12 ( <span style="background-color: yellow;">      </span> months)   | <input type="checkbox"/> More than 12 months<br><input type="checkbox"/> Client Doesn't Know<br><input type="checkbox"/> Client Refused  |   |
| Health Insurance   |  |  |   |
| <input type="checkbox"/> Yes (Enter the Source)  | <input type="checkbox"/> No  | <input type="checkbox"/> Client Doesn't Know   | <input type="checkbox"/> Client Refused |
| <b>Health Insurance Sources</b>  | <input type="checkbox"/> Private Pay Health Insurance<br><input type="checkbox"/> Medicare<br><input type="checkbox"/> MEDICAID<br><input type="checkbox"/> State Children's Health Insurance (SCHIP)<br><input type="checkbox"/> VA Medical Services  | <input type="checkbox"/> Employer Provided Health Insurance<br><input type="checkbox"/> Health Insurance obtained through COBRA<br><input type="checkbox"/> State Health Insurance Adults (Medi-cal)<br><input type="checkbox"/> Indian Health Services Program<br><input type="checkbox"/> Other _____  |   |

| Barriers:   |   |   |                          |
|---|---|---|--------------------------|
|   | Barrier Present   | Condition is Indefinite   |                          |
| Alcohol Use Disorder  | <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 Use Disorder   | <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 Health Disorder  | <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   |   |   |                          |
| <b>Domestic Violence Experience?</b>  | <input type="checkbox"/> Yes (Answer questions below)<br><input type="checkbox"/> No  | <input type="checkbox"/> Client Doesn't Know<br><input type="checkbox"/> Client Refused   |                          |
| <b>When Experience Occurred?</b>  | <input type="checkbox"/> Within the past 3 months<br><input type="checkbox"/> 3 months to 6 months ago<br><input type="checkbox"/> 6 months to one year | <input type="checkbox"/> One year ago or more<br><input type="checkbox"/> Client Doesn't Know<br><input type="checkbox"/> Client Refused  |                          |
| <b>If yes, are you currently fleeing?</b>   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No   | <input type="checkbox"/> Client Doesn't Know<br><input type="checkbox"/> Client Refused   |                          |
| Financial Assessment  |   |   |                          |
| Income Source   | Stated Income (Monthly)   | Non-Cash Resources  | Stated Amounts (Monthly) |
| <input type="checkbox"/> Yes (Check all Sources that Apply)<br><input type="checkbox"/> No<br><input type="checkbox"/> Client Doesn't Know<br><input type="checkbox"/> Client Refused |   | <input type="checkbox"/> Yes (Check all Sources that Apply)<br><input type="checkbox"/> No<br><input type="checkbox"/> Client Doesn't Know<br><input type="checkbox"/> Client Refused |                          |
| <input type="checkbox"/> Earned Income ( <i>employment wages / cash</i> )   | \$  | <input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants 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  | \$  |   |                          |
| <input type="checkbox"/> Other Income   | \$  |   |                          |