

# HMIS Intake and Enrollment Form RHY Outreach

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

Program Start Date: \_\_\_\_\_

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**

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
Ethnicity	Pregnancy Status
<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/ Non-Latino <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
Date of Engagement	Disabling Condition
____ / ____ / ____	<input type="checkbox"/> Yes <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"/> Don't Know <input type="checkbox"/> Client Refused

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Universal Data Assessment		
Client Location: CA-510 – Turlock/ Modesto/ Stanislaus County CoC		
Living Situation: BCP Only(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? ( <i>Type of residence</i> )	<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? ( <i>Length of stay in prior living situation</i> )	<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? ( <i>Approximate date started</i> )	_____/_____/_____	
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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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		
Health Insurance Sources		
<input type="checkbox"/> Private Pay Health 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 <input type="checkbox"/> Health Insurance obtained through COBRA <input type="checkbox"/> State Health Insurance Adults (Medi-cal) <input type="checkbox"/> 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
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	

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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	\$		
<b>Sexual Orientation</b>			
<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"/> Client Doesn't Know <input type="checkbox"/> Client Refused	

Contact	
Date of Contact (E.G. 05/24/2010)	____/____/____
As of today, is the client staying on the Streets, Emergency Shelter, or Safe Haven?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Worker unable to determine