# HMIS Intake and Enrollment Form
# PATH

Client DMH #: _____

**Program Start Date: (HSS6/POR1 Date)** _____

Staff Completing HMIS Form: _____

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

**BHRS/HMIS ROI Completion Date** _____/_____/_____

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

**Last Name** **Suffix**

| **Name Data Quality:** Did the client provide their full name? | **Social Security Number (SSN) And Data Quality** | **Date of Birth (DOB) and Data Quality** |
|---|---|---|
| □ 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>□ Full DOB reported<br>□ Approximate or partial DOB reported<br>□ Client Doesn't Know<br>□ Client Refused |

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

**Ethnicity**

□ Hispanic/Latino □ Non-Hispanic/ Non-Latino □ Client Doesn't Know □ Client Refused

| **Race** *(Check all that apply)* | **Gender** |
|---|---|
| □ American Indian or Alaskan 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 | □ Male<br>□ Female<br>□ Trans Female (Male to Female)<br>□ Trans Male (Female to Male)<br>□ Gender Non-Conforming (Not exclusively male or female)<br>□ Client Doesn't Know<br>□ Client Refused |

**Veteran -** *Have you ever served in the U.S. Military?*

□ Yes □ Client Doesn't Know
□ No □ Client Refused

**Relationship to Head of Household**

□ Self
□ Head of Household's Child
□ Head of Household's Spouse or Partner
□ Head of Household's other Relation Member (Other relation to head of household)
□ Other: Non-relation Member

**Program Enrollment**
(Ask the client where he/she stayed last night)

□ Outreach Place not meant for habitation (i.e. streets, under bridges, camps, camp grounds, abandoned buildings, buildings meant for animals, vehicles, public areas)

□ Supportive Services (Select this if the client's answer DOES NOT fall under "Place not meant for habitation")

**Date of Engagement** (REST-IRP completed/signed) (O/R-Intake completed)
_____/_____/_____

**Date of PATH Status Determination** (**HSS 7/POR 3 Date**) (SMI confirmed, client homeless/at risk, client agrees to services and IRP completed/signed)
_____/_____/_____

**Client Became Enrolled in PATH (HSS7/POR3)**

□ Yes (Only select when there is a PATH Status Determination Date above)
□ No **(Select options below)**
  □ Client was found ineligible for PATH (Confirmed no SMI or client is not homeless/at risk of homelessness)
  □ Client was not enrolled for another reason (i.e. Unable to confirm SMI, client left the program, IRP not yet completed)

Outreach (Place not meant for habitation) - Complete Universal Data Assessment on Page 2
Supportive Services - Complete Universal Data Assessment on Page 3

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Client DMH #: _____

| *Universal Data Assessment* | | |
|---|---|---|
| **Client Location: CA-510 – Turlock/ Modesto/ Stanislaus County CoC** | | |
| **Living Situation – *Only complete this page if you selected "Outreach" under Program Enrollment on Page 1*** | | |
| Question | Check One Answer | |
| 1. **What was your living situation last night?** | □ Place not meant for habitation | |
| **2. How long were you staying in that place?** *(Length of stay in prior living situation)* | □ One night or less<br>□ Two to six nights<br>□ One week or more, but less than one month<br>□ One month or more, but less than 90 days | □ 90 days or more, but less than one year<br>□ One year or longer<br>□ Client Doesn't Know<br>□ Client Refused |
| **3. What approximate date did you start living in a place not meant for habitation?** *(Approximate date started)* | _____/_____/_____ | |
| *Regardless of where you stayed last night, how many times have you been on the streets, in Emergency Shelter (ES), or Safe Haven (SH) in the past three years including today?* | □ One Time<br>□ Two Times<br>□ Three Times | □ Four or more times<br>□ Client Doesn't Know<br>□ Client Refused |
| *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)<br>□ 2-12 (_____ months) | □ More than 12<br>□ Client Doesn't Know<br>□ Client Refused |

***Section Complete - Continue to Wellness Assessment on Page 4***

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Client DMH #: _____

| *Universal Data Assessment* | | |
|---|---|---|
| **Client Location: CA-510 – Turlock/ Modesto/ Stanislaus County CoC** | | |
| **Living Situation – *Only complete this section if you selected "Supportive Services" under Program Enrollment on Page 1*** | | |
| **1. What was the living Situation you were living in immediately prior to project entry?**<br>***Literally Homeless Situations***<br>□ Emergency shelter, including hotel or motel paid for with emergency shelter (i.e. Mission,Respite,CHSS)<br>□ Safe Haven<br>□ Interim Housing | **2. Length of stay in prior living situation?**<br>□ One night or less<br>□ Two to six nights<br>□ One week or more, but less than one month<br>□ One month or more, but less than 90 days<br>□ 90 days or more, but less than one year<br>□ One year or longer<br>□ Client doesn't know<br>□ Client refused | **3. Did you stay less than…**<br>**Not Applicable**<br>(Continue to questions 5-7 on Page 4) |
| **1. What was the living Situation you were living in immediately prior to project entry?**<br>***Institutional Situations***<br>□ Foster care home or foster care group home<br>□ Hospital or other residential non-psychiatric medical facility<br>□ Jail, prison or juvenile detention facility<br>□ Long-term care facility or nursing home<br>□ Psychiatric hospital or other psychiatric facility<br>□ Substance abuse treatment facility or detox center | **2. Did you stay less than…**<br><br>**90 Days**<br>□ Yes (Answer 3-4)<br>□ No (Proceed Wellness Assessment on Page 4) | **3. Length of stay in prior living situation?**<br>***For Institutional Situations:***<br>□ One night or less<br>□ Two to six nights<br>□ One week or more, but less than one month<br>□ One month or more, but less than 90 days<br>□ 90 days or more, but less than one year<br>□ One year or longer<br>□ Client Doesn't Know<br>□ Client Refused |
| **1. What was the living Situation you were living in immediately prior to project entry?**<br>***Transitional & Permanent Housing Situations***<br>□ Hotel or motel paid for without emergency shelter voucher<br>□ Owned by client, no ongoing housing subsidy<br>□ Owned by client, with ongoing housing subsidy<br>□ Permanent housing (Other than RRH) for formerly homeless persons<br>□ Rental by client, no ongoing housing Subsidy *(i.e. Room and Board)*<br>□ Rental by client, with VASH subsidy<br>□ Rental by client, with GPD TIP subsidy<br>□ Rental by client, with other ongoing housing subsidy (Including RRH)<br>□ Residential project or halfway house with no homeless criteria *(i.e. Sober Living)*<br>□ Staying or living in a family member's room, apartment or house<br>□ Staying or living in a friend's room, apartment or house<br>□ Transitional housing for homeless persons (including homeless youth)<br>□ Client Doesn't Know<br>□ Client Refused | **2. Did you stay less than…**<br><br>**7 Nights**<br>□ Yes (Continue to questions 3-4)<br>□ No (Continue to question 3 then proceed to Wellness Assessment on Page 4) | **3. Length of stay in prior living situation?**<br>***For Transitional & Permanent Housing Situations:***<br>□ One night or less<br>□ Two to six nights<br>□ One week or more, but less than one month<br>□ One month or more, but less than 90 days<br>□ 90 days or more, but less than one year<br>□ One year or longer<br>□ Client Doesn't Know<br>□ Client Refused |

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| | | |
|---|---|---|
| 4. On the night before your current living situation did you stay on the streets; Emergency Shelter (ES), or Safe Haven (SH)? | □ Yes(Continue to questions 5-7)<br>□ No (Proceed to Wellness Assessment)<br>□ Client Doesn't Know (Proceed to Wellness Assessment)<br>□ Client Refused (Proceed to Wellness Assessment) | |
| 5. When did you start staying on the streets, in ES, or SH that time? *(approximate date)* | _____/_____/_____ | |
| 6. How many times have you been on the streets, in ES, or SH in the past three years? | □ One Time<br>□ Two Times<br>□ Three Times | □ Four or more times<br>□ Client Doesn't Know<br>□ 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)<br>□ 2-12 (_____ months) | □ More than 12<br>□ Client Doesn't Know<br>□ Client Refused |

***Wellness Assessment***

**Health Insurance** □ Yes **(Enter Source (s) Below)** □ No □ Client Doesn't Know □ Client Refused

□ Private Pay Health Insurance
□ Medicare
□ MEDICAID
□ State Children's Health Insurance(SCHIP)
□ VA Medical Services
□ Employer Provided Health Insurance
□ Health Insurance obtained through COBRA
□ State Funded Insurance Adults (Medi-Cal)
□ Combined Children's Health Insurance/Medicaid Program
□ Indian Health Services Program
□ Other (Specify):_____

**Connection with SOAR (Is the client connected with BHRS SSI/SSDI staff, PATH O/R staff or other SOAR staff)** □ Yes □ No □ Client Doesn't Know □ Client Refused

**Alcohol Abuse** □ Yes **(Answer Questions Below)** □ No □ Client Doesn't Know □ Client Refused

1. Expected to be of long-continued and indefinite duration and substantially impairs one's ability to live independently?
   □ Yes □ No □ Client Doesn't Know □ Client Refused
2. Documentation of disability and severity on file? (Staff Answer) □ Yes □ No
3. How confirmed? PATH ONLY (Staff Answer)
   □ Unconfirmed; presumptive or self-report □ Confirmed by prior evaluation or clinical records (ie Cerner)
   □ Confirmed through assessment and clinical evaluation

**Chronic Health Condition** □ Yes **(Answer Questions Below)** □ No □ Client Doesn't Know □ Client Refused

1. Expected to be of long-continued and indefinite duration and substantially impairs one's ability to live independently?
   □ Yes □ No □ Client Doesn't Know □ Client Refused

**Development Disability** □ Yes **(Answer Questions Below)** □ No □ Client Doesn't Know □ Client Refused

1. Expected to be of long-continued and indefinite duration and substantially impairs one's ability to live independently?
   □ Yes □ No □ Client Doesn't Know □ Client Refused

**Drug Abuse** □ Yes **(Answer Questions Below)** □ No □ Client Doesn't Know □ Client Refused

1. Expected to be of long-continued and indefinite duration and substantially impairs one's ability to live independently?
   □ Yes □ No □ Client Doesn't Know □ Client Refused
2. Documentation of disability and severity on file? (Staff Answer) □ Yes □ No
3. How confirmed? PATH ONLY (Staff Answer)
   □ Unconfirmed; presumptive or self-report □ Confirmed by prior evaluation or clinical records (ie Cerner)
   □ Confirmed through assessment and clinical evaluation

**HIV/AIDS** □ Yes **(Answer Questions Below)** □ No □ Client Doesn't Know □ Client Refused

1. Expected to be of long-continued and indefinite duration and substantially impairs one's ability to live independently?
   □ Yes □ No □ Client Doesn't Know □ Client Refused

**Mental Health** □ Yes **(Answer Questions Below)** □ No □ Client Doesn't Know □ Client Refused

1. Expected to be of long-continued and indefinite duration and substantially impairs one's ability to live independently?
   □ Yes □ No □ Client Doesn't Know □ Client Refused
2. Documentation of disability and severity on file? (Staff Answer) □ Yes □ No
3. How confirmed? PATH ONLY (Staff Answer)
   □ Unconfirmed; presumptive or self-report □ Confirmed by prior evaluation or clinical records (ie Cerner)
   □ Confirmed through assessment and clinical evaluation
4. Serious mental illness (SMI) and if SMI, how confirmed? PATH ONLY (Staff Answer)
   □ No □ Unconfirmed; presumptive or self-report

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Client DMH #: _____

| | | | | |
|---|---|---|---|---|
| □ Confirmed by prior evaluation or clinical records (ie Cerner) | | | □ Confirmed through assessment and clinical evaluation | |
| **Physical Disability** | □ Yes **(Answer Questions Below)** | □ No | □ Client Doesn't Know | □ Client Refused |
| 1. Expected to be of long-continued and indefinite duration and substantially impairs one's ability to live independently? | | | | |
| □ Yes | □ No | □ Client Doesn't Know | □ Client Refused | |
| **Disabling Condition – *If "Yes" to "Expected to be…" for any of the above barriers then this must be answered "Yes."*** | | | | |
| □ Yes | □ No | □ Client Doesn't Know | □ Client Refused | |

***Financial Assessment -*** *Check all that apply and enter amount*

| **Income Source** (Check all that apply) □ Yes ***(Check all sources below that apply)*** □ No ***(Ends this section)*** □ Client Doesn't Know ***(Ends this section)*** □ Client Refused ***(Ends this section)*** | **Stated Income (Monthly)** | **Non-Cash Resources** (Check all that apply) □ Yes ***(Check all sources below that apply)*** □ No ***(Ends this section)*** □ Client Doesn't Know ***(Ends this section)*** □ Client Refused ***(Ends this section)*** | **Stated Amount (Monthly)** |
|---|---|---|---|
| □ Earned Income *(employment wages / cash)* | $ | □ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) | $ |
| □ Unemployment Insurance | $ | □ Supplemental Nutrition Assistance Program (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 Non-Cash Sources (Specify):_____ | $ |
| □ 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 (Specify):_____ | $ | | |

| ***Contact*** | | |
|---|---|---|
| **Date of Contact (E.G. 05/24/2010)** | _____/_____/_____ | Contact Service: **570 PATH HMIS Intake Form** |
| **Will the client be staying on the streets, in Emergency Shelter, or Safe Haven tonight?** | □ Yes (I)<br>□ No (J)<br>□ Worker unable to determine (K) | |