

HMIS Data Collection Form for Project ENTRY – HUD CoC and ESG Projects

The form is broken into two sections for *All Clients* and *Head of Household and Other Adults in the Household*. Data for All Clients must be collected for each adult and child household member.

DATA FOR ALL CLIENTS

Respond to the following questions for all household members—each adult and child. A separate form should be included for each household member.

PROJECT ENTRY DATE (e.g., 08/24/2014)

The Project Entry Date will serve as the information date for all data elements collected on this form; all data must be accurate as of this date, regardless of the date collected.

		/			/					
Month		Day			Year					

NAME (first, middle, last name, suffix (e.g., Jr, Sr, III))

First name																			
Middle name																			
Last name																			
Suffix																			

NAME DATA QUALITY

- Full name reported
- Partial, street name, or code name reported
- Client doesn't know
- Client refused

SOCIAL SECURITY NUMBER

			-			-					
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DATE OF BIRTH (e.g., 10/23/1978)

		/			/					
Month		Day			Year					

SOCIAL SECURITY NUMBER DATA QUALITY

- Full SSN reported
- Approximate or partial SSN reported
- Client doesn't know
- Client refused

DATE OF BIRTH TYPE

- Full date of birth reported
- Approximate or partial date of birth reported
- Client doesn't know
- Client refused

DATA FOR ALL CLIENTS (CONTINUED)

RACE

More than one race is permitted. *Client doesn't know* and *Client refused* should only be selected if no other response is selected.

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander

- White
- Client doesn't know
- Client refused

ETHNICITY

- Non-Hispanic / Non-Latino
- Hispanic / Latino

- Client doesn't know
- Client refused

GENDER

- Female
- Male
- Transgender male to female
- Transgender female to male

- Other _____
- Client doesn't know
- Client refused

RELATIONSHIP TO HEAD OF HOUSEHOLD

- Self (head of household)
- 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

DATA FOR HEAD OF HOUSEHOLD AND OTHER ADULTS

Respond to the following questions for the head of household and each additional adult in the household. If the household is composed of an unaccompanied child, that child is the head of household. If the household is composed of two or more minors, data must be collected about the minor that has been designated as the head of household. A separate form should be included for each adult member of the household.

DISABLING CONDITION

- No
- Yes
- Client doesn't know
- Client refused

RESIDENCE PRIOR TO PROJECT ENTRY

- | | |
|---|--|
| <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher | <input type="checkbox"/> Rental by client, with VASH subsidy |
| <input checked="" type="checkbox"/> Foster care home or foster care group home | <input checked="" type="checkbox"/> Rental by client, with GPD TIP subsidy |
| <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility | <input type="checkbox"/> Rental by client, with other ongoing housing subsidy |
| <input checked="" type="checkbox"/> Hotel or motel paid for without emergency shelter voucher | <input checked="" type="checkbox"/> Residential project or halfway house with no homeless criteria |
| <input type="checkbox"/> Jail, prison, or juvenile detention facility | <input type="checkbox"/> Safe Haven |
| <input checked="" type="checkbox"/> Long-term care facility or nursing home | <input type="checkbox"/> Staying or living in a family member's room, apartment, or house |
| <input type="checkbox"/> Owned by client, no ongoing housing subsidy | <input type="checkbox"/> Staying or living in a friend's room, apartment, or house |
| <input checked="" type="checkbox"/> Owned by client, with ongoing housing subsidy | <input type="checkbox"/> Substance abuse treatment facility or detox center |
| <input type="checkbox"/> Permanent housing for formerly homeless persons (such as CoC project; HUD legacy programs; or HOPWA PH) | <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) |
| <input checked="" type="checkbox"/> Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) | <input type="checkbox"/> Other: (Describe) _____ |
| <input type="checkbox"/> Psychiatric hospital or other psychiatric facility | <input type="checkbox"/> Client doesn't know |
| <input checked="" type="checkbox"/> Rental by client, no ongoing housing subsidy | <input checked="" type="checkbox"/> Client refused |

LENGTH OF STAY IN PREVIOUS PLACE

- | | |
|---|---|
| <input type="checkbox"/> One day or less | <input type="checkbox"/> One year or longer |
| <input checked="" type="checkbox"/> Two days to one week | <input checked="" type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> More than one week, but less than one month | <input type="checkbox"/> Client refused |
| <input checked="" type="checkbox"/> One to three months | |
| <input type="checkbox"/> More than three months, but less than one year | |

DATA FOR HEAD OF HOUSEHOLD AND OTHER ADULTS (CONTINUED)

LENGTH OF TIME ON STREET, IN AN EMERGENCY SHELTER, OR SAFE HAVEN

Note: Breaks in homelessness of less than 7 days, or less than 90 days while in an institution (jail, hospital, substance abuse treatment facility, etc.) may

Is the client entering from the streets, shelter or safe haven?

No

Yes

Client doesn't know

Client refused

If yes, approximate date started:

		/			/				
Month			Day			Year			

Regardless of where they stayed last night -- Number of times the client has been homeless on the streets, in emergency shelter, or safe haven in the past three years including today.

Never in the 3 years

One time

Two times

Three times

Four or more times

Client doesn't know

Client refused

Total number of months homeless on the street, in an emergency shelter, or safe haven in the past three years

One month or less

2-12 months

More than 12 months

Client doesn't know

Client refused

VETERAN STATUS

Veteran Status is only collected on heads of household who are 18 years of age and older, as well as all other adults in the household.

No

Yes

Client doesn't know

Client refused

DATA FOR ALL CLIENTS—COC AND ESG PROJECTS

HEALTH INSURANCE

Is the client currently covered by health insurance?

No

Yes

Client doesn't know

Client refused



[IF YES] Answer 'Yes' or 'No' for each health insurance source.

Answer 'No' for sources that have been terminated, even if they were received in the past.

No	Yes	Source of non-cash benefit
<input type="checkbox"/>	<input type="checkbox"/>	Medicaid
<input type="checkbox"/>	<input type="checkbox"/>	Medicare
<input type="checkbox"/>	<input type="checkbox"/>	State Children's Health Insurance Program (or use local name)
<input type="checkbox"/>	<input type="checkbox"/>	Veteran's Administration (VA) Medical Services
<input type="checkbox"/>	<input type="checkbox"/>	Employer-Provided Health Insurance
<input type="checkbox"/>	<input type="checkbox"/>	Health insurance obtained through COBRA
<input type="checkbox"/>	<input type="checkbox"/>	Private Pay Health Insurance
<input type="checkbox"/>	<input type="checkbox"/>	State Health Insurance for Adults (or use local name)

PHYSICAL DISABILITY

Does the client currently have a physical disability?

No

Yes

Client doesn't know

Client refused



[IF YES for physical disability] Is the physical disability expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

No

Yes

Client doesn't know

Client refused

[IF YES for physical disability] Is documentation of the disability and severity on file?

No

Yes

[IF YES for physical disability] Is the client currently receiving services/treatment for this disability?

No

Yes

Client doesn't know

Client refused

DATA FOR ALL CLIENTS—COC AND ESG PROJECTS (CONTINUED)

DEVELOPMENTAL DISABILITY

Does the client currently have a developmental disability?

No

Yes

Client doesn't know

Client refused



[IF YES for developmental disability] Is the developmental disability expected to substantially impair the client's ability to live independently?

No

Yes

Client doesn't know

Client refused

[IF YES for developmental disability] Is documentation of the disability and severity on file?

No

Yes

[IF YES for developmental disability] Is the client currently receiving services/treatment for this disability?

No

Yes

Client doesn't know

Client refused

CHRONIC HEALTH CONDITION

Does the client currently have a chronic health condition?

No

Yes

Client doesn't know

Client refused



[IF YES for chronic health condition] Is the chronic health condition expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

No

Yes

Client doesn't know

Client refused

[IF YES for chronic health condition] Is documentation of the disability and severity on file?

No

Yes

[IF YES for chronic health condition] Is the client currently receiving services/treatment for this condition?

No

Yes

Client doesn't know

Client refused

DATA FOR ALL CLIENTS—COC AND ESG PROJECTS

HIV/AIDS

Does the client currently have HIV/AIDS?

No
 Yes

Client doesn't know
 Client refused



[IF YES for HIV/AIDS] Is HIV/AIDS expected to substantially impair the client's ability to live independently?

No
 Yes

Client doesn't know
 Client refused

[IF YES for HIV/AIDS] Is documentation of the disability and severity on file?

No
 Yes

[IF YES for HIV/AIDS] Is the client currently receiving services/treatment for this condition?

No
 Yes

Client doesn't know
 Client refused

MENTAL HEALTH PROBLEM

Does the client currently have a mental health problem?

No
 Yes

Client doesn't know
 Client refused



[IF YES for mental health problem] Is the mental health problem expected to be of long-continued and indefinite duration and substantially impairs the client's ability to live independently?

No
 Yes

Client doesn't know
 Client refused

[IF YES for mental health problem] Is documentation of the disability and severity on file?

No
 Yes

[IF YES for mental health problem] Is the client currently receiving services/treatment for this condition?

No
 Yes

Client doesn't know
 Client refused

DATA FOR ALL CLIENTS—COC AND ESG PROJECTS (CONTINUED)

SUBSTANCE ABUSE PROBLEM

Does the client currently have a substance abuse problem?

- | | |
|---|---|
| <input type="checkbox"/> No | <input type="checkbox"/> Both alcohol and drug abuse |
| <input checked="" type="checkbox"/> Alcohol abuse | <input checked="" type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Client refused |



[IF YES for alcohol abuse, drug abuse, or both alcohol and drug abuse for substance abuse problem] Is the substance abuse problem expected to be of long-continued and indefinite duration and substantially impairs client's ability to live independently?

- | | |
|---|--|
| <input type="checkbox"/> No | <input type="checkbox"/> Client doesn't know |
| <input checked="" type="checkbox"/> Yes | <input checked="" type="checkbox"/> Client refused |

[IF YES for alcohol abuse, drug abuse, or both alcohol and drug abuse for substance abuse problem] Is documentation of the disability and severity on file?

- | |
|---|
| <input type="checkbox"/> No |
| <input checked="" type="checkbox"/> Yes |

[IF YES for alcohol abuse, drug abuse, or both alcohol and drug abuse for substance abuse problem] Is client currently receiving services/treatment for this condition?

- | | |
|---|--|
| <input type="checkbox"/> No | <input type="checkbox"/> Client doesn't know |
| <input checked="" type="checkbox"/> Yes | <input checked="" type="checkbox"/> Client refused |

DATA FOR HEAD OF HOUSEHOLD AND OTHER ADULTS—COC AND ESG PROJECTS

INCOME AND SOURCES

Income from any source?

No

Yes

Client doesn't know

Client refused



[IF YES] Answer Yes or No for each income source. If the response for a source is 'Yes', enter the monthly amount received based on current income. If unsure of the exact monthly amount, enter client's best estimate.

Source of income	Receiving income from source?	If yes, monthly amount from source (round to nearest dollar)			
Earned income (i.e., employment income)	No				
	Yes	\$. 0 0
Unemployment Insurance	No				
	Yes	\$. 0 0
Supplemental Security Income (SSI)	No				
	Yes	\$. 0 0
Social Security Disability Income (SSDI)	No				
	Yes	\$. 0 0
VA Service-Connected Disability Compensation	No				
	Yes	\$. 0 0
VA Non-Service-Connected Disability Pension	No				
	Yes	\$. 0 0
Private disability insurance	No				
	Yes	\$. 0 0
Worker's Compensation	No				
	Yes	\$. 0 0
Temporary Assistance for Needy Families (TANF)	No				
	Yes	\$. 0 0
General Assistance (GA)	No				
	Yes	\$. 0 0
Retirement Income from Social Security	No				
	Yes	\$. 0 0
Pension or retirement income from a former job	No				
	Yes	\$. 0 0
Child support	No				
	Yes	\$. 0 0
Alimony or other spousal support	No				
	Yes	\$. 0 0
Other source If yes, source: _____	No				
	Yes	\$. 0 0
Total monthly income	Monthly income from all sources	\$. 0 0

NON-CASH BENEFITS

Non-cash benefits from any source?

No

Yes

Client doesn't know

Client refused



[IF YES] Answer 'Yes' or 'No' for each non-cash benefit source. (Answer 'No' for benefits that have been terminated, even if they were received in the past.)

No	Yes	Source of non-cash benefit
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Nutrition Assistance Program (SNAP)
<input type="checkbox"/>	<input type="checkbox"/>	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
<input type="checkbox"/>	<input type="checkbox"/>	TANF Child Care services (or use local name)
<input type="checkbox"/>	<input type="checkbox"/>	TANF transportation services (or use local name)
<input type="checkbox"/>	<input type="checkbox"/>	Other TANF-Funded Services (or use local name)
<input type="checkbox"/>	<input type="checkbox"/>	Section 8, Public Housing, or other ongoing rental assistance
<input type="checkbox"/>	<input type="checkbox"/>	Temporary rental assistance
<input type="checkbox"/>	<input type="checkbox"/>	Other source: _____

DOMESTIC VIOLENCE

Is client a domestic violence victim/survivor?

No

Yes

Client doesn't know

Client refused



[IF YES] When did the experience occur?

Within the past three months

Three to six months ago (excluding six months exactly)

Six months to one year ago (excluding one year exactly)

One year ago or more

Client doesn't know

Client refused

[IF YES] Are you currently fleeing?

No

Yes

Client doesn't know

Client refused

DATA FOR RAPID RE-HOUSING PROJECTS ONLY

Is the client in permanent housing as of the project entry date?

No

Yes



RESIDENTIAL MOVE IN DATE

[IF NO] Enter the date the client moves into permanent housing after project entry

		/			/				
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