# Homeless Resource Council of the Sierras HMIS Entry Form - ES, SO, and PATH SO

**Entry Summary**

**Project Entry Date:** _____/_____/_____ **Intake Staff Name:** _____

**Project Name:** _____ **HMIS Client ID** (ServicePoint Generated)**:** _____

**Basic Client Profile** (Universal Data Elements)

| | | | |
|---|---|---|---|
| **Name** (First, Middle, Last) | _____ | **Name Quality** | ☐Full Name<br>☐Partial, Street Name, or Code Name Reported<br>☐Client Doesn't Know ☐Client Refused |
| **SS#** | _____- _____- _____ | **Date of Birth** | _____/_____/_____ |
| **SS Quality** | ☐Full SSN ☐Client Doesn't Know<br>☐Partial SSN ☐Client Refused | **DOB Type** | ☐ Full DOB ☐Approximate or Partial DOB<br>☐Client Doesn't Know ☐Client Refused |
| **Race**<br>"P"rimary<br>"S"econdary | ☐American Indian or Alaska Native<br>☐Asian<br>☐Black or African-American<br>☐Native Hawaiian or Pacific Islander<br>☐White<br>☐Client Doesn't Know<br>☐Client Refused | **Gender** | ☐Female<br>☐Male<br>☐Trans Female (MTF or Male to Female)<br>☐Trans Male (FTM or Female to Male)<br>☐Gender Non-Conforming (i.e. not exclusively male or female<br>☐Client Doesn't Know<br>☐Client Refused |
| **Ethnicity** | ☐Hispanic/Latino ☐Client Doesn't Know<br>☐Non-Hispanic/Latino ☐Client Refused | **Disabling Condition** | ☐Yes ☐Client Doesn't Know<br>☐No ☐Client Refused |
| **Served "Active Duty" in Armed Forces?** | ☐Yes ☐Client Doesn't Know<br>☐No ☐Client Refused | **Zip Code** | _____ |
| **Type of Residence** | **Literally Homeless**<br>☐Place not meant for habitation (e.g. a vehicle, an abandoned building, bus/train/subway station, airport, or anywhere outside)<br>☐Emergency shelter, including hotel/motel paid for with emergency shelter voucher<br>☐Safe Haven<br>☐Interim Housing<br>**Institutional Situation**<br>☐Foster care home or group home<br>☐Hospital or other, 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/detox<br>**Transitional and Permanent Housing Situation**<br>☐Hotel or motel paid without emergency 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<br>☐Rental by client, with VASH housing subsidy<br>☐Rental by client, with GDP TIP subsidy<br>☐Rental by client, with other housing subsidy (including RRH)<br>☐Residential project or halfway house with no homeless criteria<br>☐Staying in family member's room, apartment or house<br>☐Staying in friend's room, apartment or house<br>☐Transitional housing for homeless persons<br>☐Client Doesn't Know<br>☐Client Refused | **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<br>☐90 days or more, but less than one year<br>☐One year or longer<br>☐Client Doesn't Know<br>☐Client Refused |
| | | **Approximate Date Started** | _____ |
| | | **Total number of times homeless on the street, in ES, or SH in the past three years** | ☐1 time<br>☐2 times<br>☐3 times<br>☐4 or more times<br>☐Client Doesn't Know<br>☐Client Refused |
| | | **Total number of months homeless on the street, in ES, or SH in the past three years** | ☐One month (this time is the first month)<br>_____2-12 months (write number)<br>☐ More than 12 months<br>☐Client Doesn't Know<br>☐Client Refused |
| | | **Relationship to HOH** | ☐Self (HoH)<br>☐HoH's Child<br>☐HoH's Spouse or Partner<br>☐HoH's other relation member<br>☐Other: non-relation member |
| | | **Client Location** | **CA-515** |

**Detailed Client Information** (Program-Level Data Elements)

| **Income Received from Any Source** | ☐Yes ☐No ☐Client Doesn't Know ☐Client Refused |
|---|---|

| **Non-Cash Benefits Received** | ☐Yes ☐No ☐Client Doesn't Know ☐Client Refused |
|---|---|

***If yes, indicate all sources and dollar amounts for applicable sources***

| **Source of Income** | **Receiving?** | **Amount** |
|---|---|---|
| Earned Income | ☐Yes ☐No | $ . |
| Unemployment Insurance | ☐Yes ☐No | $ . |
| Supplemental Security Income (SSI) | ☐Yes ☐No | $ . |
| Social Security Disability Insurance (SSDI) | ☐Yes ☐No | $ . |
| VA Service – Connected Disability Compensation | ☐Yes ☐No | $ . |
| VA Non-Service Connected Disability Pension | ☐Yes ☐No | $ . |
| Private Disability Insurance | ☐Yes ☐No | $ . |
| Workers' Compensation | ☐Yes ☐No | $ . |
| Temporary Assistance for Needy Families (TANF) | ☐Yes ☐No | $ . |
| General Assistance (GA) | ☐Yes ☐No | $ . |
| Retirement Income from Social Security | ☐Yes ☐No | $ . |
| Pension/Retirement from a former job | ☐Yes ☐No | $ . |
| Child Support | ☐Yes ☐No | $ . |
| Alimony/Spousal Support | ☐Yes ☐No | $ . |
| Other: _____ | ☐Yes ☐No | $ . |
| **Total *Monthly* Income** | | $ . |

***If yes, indicate all sources that apply***

| **Source of Non-Cash Benefit** | **Yes** | **No** |
|---|---|---|
| Supplemental Nutritional Assistance Program (SNAP) (CalFresh or "Food Stamps") | ☐ | ☐ |
| Special Supplementation Nutritional Program for (WIC) | ☐ | ☐ |
| TANF Child Care Services | ☐ | ☐ |
| TANF Transportation Services | ☐ | ☐ |
| Other TANF-Funded Services | ☐ | ☐ |
| Other:_____ | ☐ | ☐ |

| **Covered by Health Insurance** | ☐Yes ☐No ☐Client Doesn't Know ☐Client Refused |
|---|---|

***If yes, indicate all sources that apply***

| **Source of Insurance** | **Yes** | **No** |
|---|---|---|
| MEDICAID (Medi-Cal) | ☐ | ☐ |
| MEDICARE | ☐ | ☐ |
| State Children Health Insurance Program | ☐ | ☐ |
| VA Medical Services | ☐ | ☐ |
| Employer Provided Health Insurance | ☐ | ☐ |
| Health Insurance obtained through COBRA | ☐ | ☐ |
| Private Pay Health Insurance | ☐ | ☐ |
| State Health Insurance for Adults | ☐ | ☐ |
| Indian Health Services Program | ☐ | ☐ |
| Other: _____ | ☐ | ☐ |

| | | | |
|---|---|---|---|
| **Physical Disability**<br>*If Yes, expected to be of long-continued/indefinite duration; substantially impairs ability to live independently.* | ☐Yes ☐Client Doesn't Know<br>☐No ☐Client Refused<br><br>☐Yes ☐Client Doesn't Know<br>☐No ☐Client Refused | **Developmental Disability**<br>*If Yes, expected to be of long-continued/indefinite duration; substantially impairs ability to live independently.* | ☐Yes ☐Client Doesn't Know<br>☐No ☐Client Refused<br><br>☐Yes ☐Client Doesn't Know<br>☐No ☐Client Refused |
| **Chronic Health Condition**<br>*If Yes, expected to be of long-continued/indefinite duration; substantially impairs ability to live independently.* | ☐Yes ☐Client Doesn't Know<br>☐No ☐Client Refused<br><br>☐Yes ☐Client Doesn't Know<br>☐No ☐Client Refused | **HIV/AIDS**<br>*If Yes, expected to substantially impairs ability to live independently.* | ☐Yes ☐Client Doesn't Know<br>☐No ☐Client Refused<br><br>☐Yes ☐Client Doesn't Know<br>☐No ☐Client Refused |
| **Mental Health Problem**<br>*If Yes, expected to be of long-continued/indefinite duration; substantially impairs ability to live independently.* | ☐Yes ☐Client Doesn't Know<br>☐No ☐Client Refused<br><br>☐Yes ☐Client Doesn't Know<br>☐No ☐Client Refused | **Substance Abuse Problem**<br><br>*If Yes, expected to be of long-continued/indefinite duration; substantially impairs ability to live independently.* | ☐Alcohol Abuse ☐Drug Abuse<br>☐Both Alcohol & Drug Abuse<br>☐No ☐Client Doesn't Know<br>☐Client Refused<br><br>☐Yes ☐Client Doesn't Know<br>☐No ☐Client Refused |

| | | | |
|---|---|---|---|
| **DV Victim/Survivor** | ☐Yes<br>☐No<br>☐Client Doesn't Know<br>☐Client Refused | *If Yes, when experience occurred*<br><br>*If yes, are you currently fleeing?* | ☐Within past three months ☐Client Doesn't Know<br>☐Three to six months ago ☐Client Refused<br>☐Six to twelve months ago ☐More than a year ago<br><br>☐Yes ☐Client Doesn't Know<br>☐No ☐Client Refused |

| **Street Outreach/Night by Night Shelter Stays/PATH Street Outreach Only** | | | |
|---|---|---|---|
| **Contact Date** | _____/_____/_____ | **Staying on Streets, ES, SH** | ☐Yes<br>☐No<br>☐Worker Unable to determine |
| **Date of Engagement** | _____/_____/_____ | | |

| **PATH Projects Only** | | | |
|---|---|---|---|
| **PATH Status** | | | |
| **Client became enrolled in PATH** | ☐Yes ☐No | *If NO, reason not enrolled* | ☐Client was found ineligible for PATH<br>☐Client was not enrolled for other reason(s) |
| *Date of Determination* | | _____/_____/_____ | |

| | |
|---|---|
| **Connection with SOAR** | ☐Yes ☐No |