Homeless Resource Council of the Sierras HMIS Entry Form - PSH, RRH, TH and HP

Intake 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 ☐Partial, Street Name, or Code Name Reported ☐Client Doesn't Know ☐Client Refused
SS#	_____- _____- _____	**Date of Birth**	_____/_____/_____
SS Quality	☐Full SSN ☐Client Doesn't Know ☐Partial SSN ☐Client Refused	**DOB Type**	☐ Full DOB ☐Approximate or Partial DOB ☐Client Doesn't Know ☐Client Refused
Race "P"rimary "S"econdary	☐American Indian or Alaska Native ☐Asian ☐Black or African-American ☐Native Hawaiian or Pacific Islander ☐White ☐Client Doesn't Know ☐Client Refused	**Gender**	☐Female ☐Male ☐Trans Female (MTF or Male to Female) ☐Trans Male (FTM or Female to Male) ☐Gender Non-Conforming (i.e. not exclusively male or female) ☐Client Doesn't Know ☐Client Refused
Ethnicity	☐Hispanic/Latino ☐Client Doesn't Know ☐Non-Hispanic/Latino ☐Client Refused	**Disabling Condition**	☐Yes ☐Client Doesn't Know ☐No ☐Client Refused
Served "Active Duty" in Armed Forces?	☐Yes ☐Client Doesn't Know ☐No ☐Client Refused	**Zip Code**	_____

Living Situation *(Select only ONE Type of Residence and sub-questions)*

Type of Residence

Literally Homeless

☐Place not meant for habitation (e.g. a vehicle, an abandoned building, bus/train/subway station, airport, or anywhere outside)
☐Emergency shelter, including hotel/motel paid for with emergency shelter voucher
☐Safe Haven
☐Interim Housing

Length of Stay _____ days

Approximate Date Most Recent Occurrence of Homelessness Started _____ *Once complete, go to CH Questions below.*

Type of Residence

Institutional Situation

☐Foster care home or group home
☐Hospital or other, non-psychiatric, medical facility
☐Jail, prison, or juvenile detention facility
☐Long term care facility or nursing home
☐Psychiatric hospital or other psychiatric facility
☐Substance abuse treatment facility/detox

Length of Stay _____ days *If more than 90 days, skip to next page.*

On the night before, did you stay on the streets, in ES, or SH ☐Yes ☐No

Approximate Date Most Recent Occurrence of Homelessness Started _____ *Once complete, go to CH Questions below.*

Type of Residence

Transitional and Permanent Housing Situation

☐Hotel or motel paid without emergency voucher
☐Owned by client, no ongoing housing subsidy
☐Owned by client, with ongoing housing subsidy
☐Permanent housing (other than RRH) for formerly homeless persons
☐Rental by client, no ongoing housing subsidy
☐Rental by client, with VASH housing subsidy
☐Rental by client, with GDP TIP subsidy
☐Rental by client, with other housing subsidy (including RRH)
☐Residential project or halfway house with no homeless criteria
☐Staying in family member's room, apartment or house
☐Staying in friend's room, apartment or house
☐Transitional housing for homeless persons
☐Client Doesn't Know
☐Client Refused

Length of Stay _____ days *If more than 7 days, skip to next page.*

On the night before, did you stay on the streets, in ES, or SH ☐Yes ☐No

Approximate Date Most Recent Occurrence of Homelessness Started _____ *Once complete, go to CH Questions below.*

CH Questions

(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	☐1 time ☐2 times ☐3 times ☐4 or more times ☐Client Doesn't Know ☐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) _____2-12 months (write number) ☐ More than 12 months ☐Client Doesn't Know ☐Client Refused

Relationship to HOH	☐Self (HoH) ☐HoH's Spouse or Partner ☐HoH's Child ☐HoH's other relation member ☐Other: non-relation member	**Client Location**	**CA-515**

Detailed Client Information (Program-Level Data Elements)

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

If yes, indicate all sources and dollar amounts for applicable sources			***If yes, indicate all sources that apply***		
Source of Income	**Receiving?**	**Amount**	**Source of Non-Cash Benefit**	**Yes**	**No**
Earned Income	☐Yes ☐No	$.	Supplemental Nutritional Assistance Program (SNAP) (CalFresh or "Food Stamps")	☐	☐
Unemployment Insurance	☐Yes ☐No	$.	Special Supplementation Nutritional Program for (WIC)	☐	☐
Supplemental Security Income (SSI)	☐Yes ☐No	$.	TANF Child Care Services	☐	☐
Social Security Disability Insurance (SSDI)	☐Yes ☐No	$.	TANF Transportation Services	☐	☐
VA Service – Connected Disability Compensation	☐Yes ☐No	$.	Other TANF-Funded Services	☐	☐
VA Non-Service Connected Disability Pension	☐Yes ☐No	$.	Other:_____	☐	☐
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		$.			

Covered by Health Insurance	☐Yes ☐Client Doesn't Know ☐No ☐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 Insurance	☐	☐
Other: _____	☐	☐

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

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

Permanent Housing Projects (RRH and PSH Only)	
Housing Move-In Date	_____/_____/_____