

HMIS INTAKE - RHY Street Outreach MINOR (under 18 years of age) as Household Member

PROJECT	
INTAKE DATE	PRIMARY WORKER
/ /	

FIRST NAME	MIDDLE NAME	LAST NAME (and Suffix)
NAME DATA QUALITY		
<input type="checkbox"/> Full Name Reported	<input type="checkbox"/> Partial Name, Street Name or Code Name Reported	
<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
ALIAS		

SOCIAL SECURITY NUMBER		
_ - _ - _ - _ - _ -		
SSN DATA QUALITY		
<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"/> Data Not Collected

GENDER		
<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Transgender Female to Male	<input type="checkbox"/> Transgender Male to Female	
<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected

SEXUAL ORIENTATION		
<input type="checkbox"/> Heterosexual	<input type="checkbox"/> Gay	<input type="checkbox"/> Lesbian
<input type="checkbox"/> Bisexual	<input type="checkbox"/> Questioning/Unsure	
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected

BIRTHDATE		
/ /		
BIRTHDATE DATA QUALITY		
<input type="checkbox"/> Full DOB Reported	<input type="checkbox"/> Approximate or Partial DOB Reported	
<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected

ETHNICITY		
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Non-Hispanic	
<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
RACE (choose all that apply)		
<input type="checkbox"/> American Indian/Native Alaskan	<input type="checkbox"/> Asian	<input type="checkbox"/> White
<input type="checkbox"/> Black or African-American	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	
<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected

STREET (MAILING) ADDRESS		
CITY	STATE	ZIP
COUNTY	PHONE	MOVE-IN DATE

COVERED BY HEALTH INSURANCE				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
IF YES:				
MEDICAID	<input type="checkbox"/> No <input type="checkbox"/> Yes	MEDICARE.....	<input type="checkbox"/> No <input type="checkbox"/> Yes	
State Children's Health Insurance Program	<input type="checkbox"/> No <input type="checkbox"/> Yes	VA Medical Services.....	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Employer provided Health insurance	<input type="checkbox"/> No <input type="checkbox"/> Yes	Health ins. via COBRA	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Private Pay Health Insurance.....	<input type="checkbox"/> No <input type="checkbox"/> Yes	State Health Ins. Adults	<input type="checkbox"/> No <input type="checkbox"/> Yes	

SPECIAL NEEDS				
PHYSICAL DISABILITY				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
IF YES:				
Expected to substantially impair ability to live independently:				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
Documentation of the disability and severity on file:				
<input type="checkbox"/> No <input type="checkbox"/> Yes				
Currently receiving services or treatment for this condition:				
<input type="checkbox"/> No <input type="checkbox"/> Yes				

DEVELOPMENTAL DISABILITY				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
IF YES:				
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
Documentation of the disability and severity on file:				
<input type="checkbox"/> No <input type="checkbox"/> Yes				
Currently receiving services or treatment for this condition:				
<input type="checkbox"/> No <input type="checkbox"/> Yes				

CHRONIC HEALTH CONDITION				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
IF YES:				
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
Documentation of the disability and severity on file:				
<input type="checkbox"/> No <input type="checkbox"/> Yes				
Currently receiving services or treatment for this condition:				
<input type="checkbox"/> No <input type="checkbox"/> Yes				

HIV/AIDS				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
IF YES:				
Expected to substantially impair ability to live independently:				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
Documentation of the disability and severity on file:				
<input type="checkbox"/> No <input type="checkbox"/> Yes				
Currently receiving services or treatment for this condition:				
<input type="checkbox"/> No <input type="checkbox"/> Yes				

MENTAL HEALTH				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
IF YES:				
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
Documentation of the disability and severity on file: <input type="checkbox"/> No <input type="checkbox"/> Yes				
Currently receiving services or treatment for this condition: <input type="checkbox"/> No <input type="checkbox"/> Yes				

SUBSTANCE ABUSE PROBLEM				
<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Both Alcohol and Drug Abuse		
<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected	
IF YES:				
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
Documentation of the disability and severity on file: <input type="checkbox"/> No <input type="checkbox"/> Yes				
Currently receiving services or treatment for this condition: <input type="checkbox"/> No <input type="checkbox"/> Yes				

COMMERCIAL SEXUAL EXPLOITATION				
RECEIVED SOMETHING IN EXCHANGE FOR SEX IN THE PAST 3 MONTHS?				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
(If yes) Number of times:				
<input type="checkbox"/> 1-3	<input type="checkbox"/> 4-7	<input type="checkbox"/> 8-30	<input type="checkbox"/> More than 30	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
(If yes) Did someone ask/make you have sex?				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	

HOUSEHOLD SIZE

CHILDREN'S EDUCATION QUESTIONS				
EDUCATION/ENROLLMENT STATUS				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
If Yes, was/is the child connected to the McKinney Vento Homeless Assistance Act school liaison?				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
TYPE OF SCHOOL				
<input type="checkbox"/> Public	<input type="checkbox"/> Parochial or other private school	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
LAST DATE OF ENROLLMENT		SCHOOL NAME		
<i>(if not currently enrolled)</i> / /				
BARRIERS TO ENROLLMENT				
<input type="checkbox"/> None	<input type="checkbox"/> School Selection	<input type="checkbox"/> Immunization or other medical records		
<input type="checkbox"/> Residency Required	<input type="checkbox"/> Legal Guardianship Requirements	<input type="checkbox"/> School Records		
<input type="checkbox"/> Transportation	<input type="checkbox"/> Other Enrollment Issues	<input type="checkbox"/> Birth Certificates		
<input type="checkbox"/> Physical Examination Records				

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SERVICES SOUGHT		
<input type="checkbox"/> Shelter/Housing	<input type="checkbox"/> Drug Treatment	<input type="checkbox"/> Mental Health Care
<input type="checkbox"/> Medical Care	<input type="checkbox"/> Legal Aid - CRJS/Civil	<input type="checkbox"/> Legal Aid - Immigration

NOTES

CARES Regional HMIS Consumer Information Consent Form

Information collected in the HMIS database is protected in compliance with the standards set forth in the Health Insurance Portability and Accountability Act (HIPAA) and the U.S. Department of Housing and Urban Development HMIS Data Standards. Every person and agency that is authorized to read or enter information into the database has signed an agreement to maintain the security and confidentiality of the information. Any person or agency that is found to violate their agreement may have their access rights terminated and may be subject to further penalties.

I UNDERSTAND THAT:

- The partner agencies may share limited identifying information about the people they serve with other parties working to end homelessness.
- The release of my information does not guarantee that I will receive assistance. This release of information includes public funded cash disbursements received during the past 3 years.
- This authorization will remain in effect for a minimum of 36 months unless I revoke it in writing, and I may revoke authorization at any time by signing a written statement or Revocation form.
- The following personal information will NOT be shared with any HMIS partner agencies via this HMIS computer system.
 - HIV/AIDS information, such as status, diagnostic test results, mode of transmission, sexuality.
 - Domestic violence information, such as abuse history, abuser information, trauma information.
 - Behavioral health information, such as substance and alcohol abuse and mental illness.
 - Clients supportive services contacts, medication information and case notes.
- If I revoke my authorization, all information about me already in the database will remain, but will become invisible to all of the partner agencies, except public (county, state or federal) cash disbursements.
- If I am applying for county, state or federal cash disbursements such as ESG or SSVF, this information will be shared with Collaborative users and State agencies.

By signing this form, I agree to share the following level of information with other partner agencies via the HMIS computer system:

- I agree to share my name (first, middle, last), gender, program enrollment, and exit dates information via the HMIS system with other partner agencies.*
- I agree to share my name, gender, ancestry, program enrollment and exit dates, demographic information, miscellaneous section, and contacts information, cash disbursements via the HMIS system with other partner agencies.*
- I do not agree to share any of my information via the HMIS system with other HMIS partner agencies via the HMIS computer system. Exception is cash disbursements as noted above.*

Signature: _____ Date: _____