

# HMIS INTAKE – RHY

## Maternity Group Home or Transitional Living

PROJECT		
INTAKE DATE	BED/UNIT	PRIMARY WORKER
/ /		

FIRST NAME	MIDDLE NAME	LAST NAME (and Suffix)
NAME DATA QUALITY		ALIAS
<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		

SOCIAL SECURITY NUMBER	SSN DATA QUALITY
<i>(enter "9" for any missing numbers in an Approximate or Partial SSN)</i>  _ _ _ - _ _ - _ _ _	<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"/> Doesn't Identify as male or female or transgender
<input type="checkbox"/> Transgender Female to Male	<input type="checkbox"/> Transgender Male to Female	<input type="checkbox"/> Data Not Collected
<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	

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"/> Black	<input type="checkbox"/> White
<input type="checkbox"/> Asian	<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

VETERAN 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

**LIVING SITUATION**

*Based on the client's living situation the night before project entry, record responses in **one (1) section** below, EITHER Homeless Situation, Institutional Situation OR Transitional/Permanent Situation.  
If the client's living situation the night before project entry is unknown, fill in the section called Unknown.*

HOMELESS SITUATIONS:	
TYPE OF RESIDENCE NIGHT BEFORE PROJECT ENTRY:	LENGTH OF STAY IN PREVIOUS PLACE
<input type="checkbox"/> Place not meant for human habitation (vehicle, abandoned building, bus/train/subway station etc) <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher <input type="checkbox"/> Safe Haven <input type="checkbox"/> Interim Housing	<input type="checkbox"/> 1 night or less <input type="checkbox"/> 2 to 6 nights <input type="checkbox"/> 1 week or more, but less than 1 month <input type="checkbox"/> 1 month or more, but less than 90 days <input type="checkbox"/> 90 days or more, but less than 1 year <input type="checkbox"/> 1 year or longer <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected
APPROXIMATE DATE HOMELESSNESS STARTED:	NUMBER OF TIMES THE CLIENT HAS BEEN ON THE STREETS, IN ES, OR SH IN THE PAST THREE YEARS INCLUDING TODAY:
___/___/___	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4+ <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected
TOTAL NUMBER OF MONTHS HOMELESS ON THE STREETS, IN ES, OR SH IN LAST THREE YEARS:	
<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> More than 12 <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	

**OR**

INSTITUTIONAL SITUATIONS:	
TYPE OF RESIDENCE NIGHT BEFORE PROJECT ENTRY:	Did you stay less than 90 Days?
<input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail, prison or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center	<input type="checkbox"/> No <input type="checkbox"/> Yes →  (If Yes) On the night before did you stay on the streets, ES, or SH? <input type="checkbox"/> No <input type="checkbox"/> Yes →
IF YES TO 'ON THE NIGHT BEFORE DID YOU STAY ON THE STREETS, ES OR SH?' PROVIDE DETAILS OF PREVIOUS HOMELESSNESS:	
APPROXIMATE DATE HOMELESSNESS STARTED:	NUMBER OF TIMES THE CLIENT HAS BEEN ON THE STREETS, IN ES, OR SH IN THE PAST THREE YEARS INCLUDING TODAY:
___/___/___	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4+ <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected
TOTAL NUMBER OF MONTHS HOMELESS ON THE STREETS, IN ES, OR SH IN LAST THREE YEARS:	
<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> More than 12 <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	

**OR**

**TRANSITIONAL AND PERMANENT HOUSING SITUATIONS:**

TYPE OF RESIDENCE NIGHT BEFORE PROJECT ENTRY:

- |  |   |
|--|---|
| <input type="checkbox"/> Hotel or Motel paid for without emergency voucher   | <input type="checkbox"/> Rental by client with VASH subsidy                               |
| <input type="checkbox"/> Owned by client, no ongoing subsidy   | <input type="checkbox"/> Rental by client with other ongoing housing subsidy              |
| <input type="checkbox"/> Owned by client WITH ongoing subsidy  | <input type="checkbox"/> Residential project or halfway house with no homeless criteria   |
| <input type="checkbox"/> Perm. Supportive housing for formerly homeless persons (CoC project, HUD legacy program, HOPWA) | <input type="checkbox"/> Staying or in a family member's room, apartment or house         |
| <input type="checkbox"/> Rental by client, no ongoing subsidy  | <input type="checkbox"/> Staying or in a friend's room, apartment or house                |
| <input type="checkbox"/> Rental by client with GPD TIP subsidy   | <input type="checkbox"/> Transitional housing for homeless persons (incl. homeless youth) |

DID YOU STAY LESS THAN 7 DAYS?

- No       Yes →

(If Yes) On the night before did you stay on the streets, ES, or SH?

- No       Yes →

IF YES TO 'ON THE NIGHT BEFORE DID YOU STAY ON THE STREETS, ES OR SH?' PROVIDE DETAILS OF PREVIOUS HOMELESSNESS:

APPROXIMATE DATE HOMELESSNESS STARTED:

NUMBER OF TIMES THE CLIENT HAS BEEN ON THE STREETS, IN ES, OR SH IN THE PAST THREE YEARS INCLUDING TODAY:

\_\_\_/\_\_\_/\_\_\_

- 1     2     3     4+     Client Doesn't Know     Client Refused  
 Data Not Collected

TOTAL NUMBER OF MONTHS HOMELESS ON THE STREETS, IN ES, OR SH IN LAST THREE YEARS:

- 1     2     3     4     5     6     7     8     9     10     11     12     More than 12  
 Client Doesn't Know     Client Refused     Data Not Collected

**OR**

**UNKNOWN OPTIONS:**

TYPE OF RESIDENCE NIGHT BEFORE PROJECT ENTRY:

- Client doesn't know  
 Client refused  
 Data not collected

**HOUSING STATUS**

- |  |   |
|--|---|
| <input type="checkbox"/> Category 1 - Homeless                                   | <input type="checkbox"/> At-risk of homelessness                                    |
| <input type="checkbox"/> Category 2 - At imminent risk of losing housing         | <input type="checkbox"/> Stably housed  |
| <input type="checkbox"/> Category 3 - Homeless only under other federal statutes | <input type="checkbox"/> Client doesn't know  |
| <input type="checkbox"/> Category 4 - Fleeing domestic violence                  | <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected |

**MATERNITY GROUP HOME AND TRANSITIONAL LIVING ONLY: INCOME FROM ANY SOURCE (monthly)**

- No       Yes       Client Doesn't Know       Client Refused       Data Not Collected

IF YES:

- |  |   |
|--|---|
| <input type="checkbox"/> Earned Income.....\$ _____                                | <input type="checkbox"/> Unemployment Insurance..... \$ _____                     |
| <input type="checkbox"/> SSI .....\$ _____   | <input type="checkbox"/> SSDI .....\$ _____                                       |
| <input type="checkbox"/> VA Service-Connected Disability Compensation.....\$ _____ | <input type="checkbox"/> VA Non-Service Connected Disability Pension.... \$ _____ |
| <input type="checkbox"/> Private Disability Insurance.....\$ _____                 | <input type="checkbox"/> Worker's Compensation ..... \$ _____                     |
| <input type="checkbox"/> TANF.....\$ _____   | <input type="checkbox"/> General Public Assistance..... \$ _____                  |
| <input type="checkbox"/> Retirement from SSA.....\$ _____                          | <input type="checkbox"/> Pension or Retirement from former job ..... \$ _____     |
| <input type="checkbox"/> Child Support.....\$ _____                                | <input type="checkbox"/> Alimony or Other Spousal Support..... \$ _____           |
| <input type="checkbox"/> Other .....\$ _____                                       |   |

<b>NON CASH BENEFITS FROM ANY SOURCE</b>				
<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:				
<input type="checkbox"/> SNAP	<input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants and Children			
<input type="checkbox"/> TANF Child Care Services	<input type="checkbox"/> TANF Transportation Services		<input type="checkbox"/> Other TANF Funded Srvcs	
<input type="checkbox"/> Section 8, Public Housing or Other Ongoing Rental Assistance			<input type="checkbox"/> Temporary Rental Assistance	
<input type="checkbox"/> Other Source				
<b>COVERED BY HEALTH INSURANCE</b>				
<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
Indian Health Services .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Other (if yes please specify .....	<input type="checkbox"/> No <input type="checkbox"/> Yes

<b>PHYSICAL DISABILITY</b>				
<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:				
<b>Expected to substantially impair ability to live independently:</b>				
<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
<b>Documentation of the disability and severity on file:</b> .....				
<input type="checkbox"/> No <input type="checkbox"/> Yes				
<b>Currently receiving services or treatment for this condition:</b> .....				
<input type="checkbox"/> No <input type="checkbox"/> Yes				

<b>DEVELOPMENTAL DISABILITY</b>				
<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:				
<b>Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:</b>				
<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
<b>Documentation of the disability and severity on file:</b> .....				
<input type="checkbox"/> No <input type="checkbox"/> Yes				
<b>Currently receiving services or treatment for this condition:</b> .....				
<input type="checkbox"/> No <input type="checkbox"/> Yes				

<b>CHRONIC HEALTH CONDITION</b>				
<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:				
<b>Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:</b>				
<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
<b>Documentation of the disability and severity on file:</b> .....				
<input type="checkbox"/> No <input type="checkbox"/> Yes				
<b>Currently receiving services or treatment for this condition:</b> .....				
<input type="checkbox"/> No <input type="checkbox"/> Yes				

<b>HIV/AIDS</b>				
<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:				
<b>Expected to substantially impair ability to live independently:</b>				
<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
<b>Documentation of the disability and severity on file:</b> .....				
<input type="checkbox"/> No <input type="checkbox"/> Yes				
<b>Currently receiving services or treatment for this condition:</b> .....				
<input type="checkbox"/> No <input type="checkbox"/> Yes				

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

RHY-BCP STATUS	
FYSB YOUTH	(IF NO) REASON FOR NOT PROVIDING SERVICES
<input type="checkbox"/> No	<input type="checkbox"/> Out of age range
<input type="checkbox"/> Yes	<input type="checkbox"/> Ward of the State - Immediate Reunification
	<input type="checkbox"/> Ward of the Criminal Justice System - Immediate Reunification
	<input type="checkbox"/> Other

LAST GRADE COMPLETED		
<input type="checkbox"/> Less than Grade 5	<input type="checkbox"/> Grades 5-6	<input type="checkbox"/> Grades 7-8
<input type="checkbox"/> Grades 9-11	<input type="checkbox"/> Grade 12	<input type="checkbox"/> School does not have grade levels
<input type="checkbox"/> GED	<input type="checkbox"/> Some College	<input type="checkbox"/> Associate's degree
<input type="checkbox"/> Bachelor's degree	<input type="checkbox"/> Graduate degree	<input type="checkbox"/> Vocational certification
<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected

SCHOOL STATUS		
<input type="checkbox"/> Attending school regularly	<input type="checkbox"/> Attending school irregularly	<input type="checkbox"/> Graduated from high school
<input type="checkbox"/> Obtained GED	<input type="checkbox"/> Dropped out	<input type="checkbox"/> Suspended
<input type="checkbox"/> Expelled	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
<input type="checkbox"/> Data not collected	<input type="checkbox"/> Not Applicable	

EMPLOYMENT 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: TYPE OF EMPLOYMENT			
<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Seasonal/Sporadic (including Day Labor)	
<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected	

IF NO: WHY NOT EMPLOYED?		
<input type="checkbox"/> Looking for Work	<input type="checkbox"/> Unable to Work	<input type="checkbox"/> Not looking for work

GENERAL HEALTH STATUS			
<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair
<input type="checkbox"/> Poor	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected

DENTAL HEALTH STATUS			
<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair
<input type="checkbox"/> Poor	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected

MENTAL HEALTH STATUS			
<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair
<input type="checkbox"/> Poor	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected

CURRENTLY PREGNANT	IF YES
<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>Due Date:</b> ____/____/____

FORMERLY A WARD OF CHILD WELFARE OR FOSTER CARE AGENCY				
<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
<b>If yes:</b> <input type="checkbox"/> Less than 1 year <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 3 to 5 or more years				
<b>If less than 1 year, number of months:</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11				

FORMERLY A WARD OF THE JUVENILE JUSTICE SYSTEM				
<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
<b>If yes:</b> <input type="checkbox"/> Less than 1 year <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 3 to 5 or more years				
<b>If less than 1 year, number of months:</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11				

YOUNG PERSON'S CRITICAL ISSUES	
<input type="checkbox"/> Household Dynamics	<input type="checkbox"/> Physical Disability - Youth
<input type="checkbox"/> Sexual Orientation/Gender Identity - Youth	<input type="checkbox"/> Physical Disability - Family member
<input type="checkbox"/> Sexual Orientation/Gender Identity - Family member	<input type="checkbox"/> Mental Disability - Youth
<input type="checkbox"/> Housing Issues - Youth	<input type="checkbox"/> Mental Disability - Family member
<input type="checkbox"/> Housing Issues - Family member	<input type="checkbox"/> Abuse and Neglect - Youth
<input type="checkbox"/> School or Educational Issues - Youth	<input type="checkbox"/> Abuse and Neglect - Family member
<input type="checkbox"/> School or Educational Issues - Family member	<input type="checkbox"/> Alcohol or other drug abuse - Youth
<input type="checkbox"/> Unemployment - Youth	<input type="checkbox"/> Alcohol or other drug abuse - Family member
<input type="checkbox"/> Unemployment - Family member	<input type="checkbox"/> Insufficient Income to support youth - Family member
<input type="checkbox"/> Mental Health Issues - Youth	<input type="checkbox"/> Active Military Parent - Family member
<input type="checkbox"/> Mental Health Issues - Family member	<input type="checkbox"/> Incarcerated Parent of Youth
<input type="checkbox"/> Health Issues - Youth	<input type="checkbox"/> None of the above
<input type="checkbox"/> Health Issues - Family member	

RHY REFERRAL SOURCE	
<input type="checkbox"/> Self-Referral	<input type="checkbox"/> Residential Project: Independent Living Project
<input type="checkbox"/> Individual: Parent/Guardian	<input type="checkbox"/> Residential Project: Job Corps
<input type="checkbox"/> Individual: Relative or Friend	<input type="checkbox"/> Residential Project: Drug Treatment Center
<input type="checkbox"/> Individual: Other Adult or Youth	<input type="checkbox"/> Residential Project: Treatment Center
<input type="checkbox"/> Individual: Partner/Spouse	<input type="checkbox"/> Residential Project: Educational Institute
<input type="checkbox"/> Individual: Foster Parent	<input type="checkbox"/> Residential Project: Other Agency project
<input type="checkbox"/> Outreach Project: FYSB	<input type="checkbox"/> Residential Project: Other Project
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Hotline: National Runaway Switchboard
<input type="checkbox"/> Client refused	<input type="checkbox"/> Hotline: Other
<input type="checkbox"/> Outreach Project: Other	<input type="checkbox"/> Other Agency: Child Welfare/CPS
<input type="checkbox"/> Temporary Shelter: FYSB Basic Center Project	<input type="checkbox"/> Other Agency: Non-Residential Independent Living Project
<input type="checkbox"/> Temporary Shelter: Other Youth Only Emergency Shelter	<input type="checkbox"/> Other Project Operated by your Agency
<input type="checkbox"/> Temporary Shelter: Emergency Shelter for Families	<input type="checkbox"/> Other Youth Services Agency
<input type="checkbox"/> Temporary Shelter: Emergency Shelter for Individuals	<input type="checkbox"/> Juvenile Justice
<input type="checkbox"/> Temporary Shelter: Domestic Violence Shelter	<input type="checkbox"/> Law Enforcement/Police
<input type="checkbox"/> Temporary Shelter: Safe Place	<input type="checkbox"/> Religious Organization
<input type="checkbox"/> Temporary Shelter: Other	<input type="checkbox"/> Mental Hospital
<input type="checkbox"/> Residential Project: FYSB Transitional Living Project	<input type="checkbox"/> School
<input type="checkbox"/> Residential Project: Other Transitional Living Project	<input type="checkbox"/> Other Organization
<input type="checkbox"/> Residential Project: Group Home	<input type="checkbox"/> Data not collected

COMMERCIAL SEXUAL EXPLOITATION	
EVER RECEIVED ANYTHING IN EXCHANGE FOR SEX (E.G. MONEY, FOOD DRUGS, SHELTER)?	
<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	
<b>(If yes) Number of times:</b>	
<b>(If yes) Did someone ask/make you have sex?</b>	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
IF YES:	
<b>How many times?</b>	
<input type="checkbox"/> 1-3	<input type="checkbox"/> 4-7
<input type="checkbox"/> 8-11	<input type="checkbox"/> 12 or more
<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
<input type="checkbox"/> Data Not Collected	
<b>In the last three months?</b>	
<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	
<b>Ever made/persuaded to have sex in exchange for something?</b>	
<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	
<b>(If yes) Made/persuaded in the last three months?</b>	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused

COMMERCIAL LABOR EXPLOITATION	
EVER AFRAID TO QUIT/LEAVE WORK DUE TO THREATS OF VIOLENCE TO YOURSELF, FAMILY OR FRIENDS?	
<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	
EVER PROMISED WORK WHERE WORK OR PAYMENT DIFFERENT THAN YOU EXPECTED?	
<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 (TO EITHER):	
<b>Felt forced, pressured or tricked into continuing the job?</b>	
<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	
<b>In the last three months?</b>	
<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	

INDIVIDUAL/FAMILY TYPE		
<input type="checkbox"/> Individual Male	<input type="checkbox"/> Individual Female	<input type="checkbox"/> Individual Male Youth (<18)
<input type="checkbox"/> Individual Female Youth (<18)	<input type="checkbox"/> Single Parent Family, Male Head	<input type="checkbox"/> Single Parent Family, Female Head
<input type="checkbox"/> Single Parent Family, Youth Head (<18)	<input type="checkbox"/> Two Parent Family, Adult	<input type="checkbox"/> Two Parent Family, Youth
<input type="checkbox"/> Adult Couple without Children	<input type="checkbox"/> N/A	

ZIP CODE OF LAST PERMANENT ADDRESS	ZIP CODE DATA QUALITY	DATE LEFT LAST PERMANENT ADDRESS
	<input type="checkbox"/> Full or Partial Zip Code <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	/ /

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

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*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: \_\_\_\_\_