

CARES REGIONAL HMIS INTAKE – EMERGENCY SHELTER

| | | |
|----------------------------|------------------|----------------|
| *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 <i>(enter "9" for any missing numbers in an Approximate or Partial SSN)</i> _____ - ____ - _____ | *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"/> Trans Male(FTM) |
| <input type="checkbox"/> Trans Female(MTF) | <input type="checkbox"/> Gender Non-Conforming | |
| <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 |

| | | | | |
|-----------------------------|------------------------------|--|---|---|
| *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: | |
| <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 | |
| LENGTH OF STAY IN PREVIOUS PLACE | |
| <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: | |
|--|---|
| <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 |
| DID YOU STAY LESS THAN 90 DAYS | |
| <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: | |
|--|---|
| <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? | |
| <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

| UNKNOWN OPTIONS: | | |
|--|---|---|
| <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Client refused | <input type="checkbox"/> Data not collected |

| *INCOME FROM ANY SOURCE (monthly) | | | | |
|--|------------------------------|---|---|---|
| <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"/> 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..... | \$ _____ | | | |
| *NON-CASH BENEFITS FROM ANY SOURCE | | | | |
| <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 Service |
| <input type="checkbox"/> Other TANF Funded Svcs | <input type="checkbox"/> Other Source |
| *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 |
| Indian Health Services | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Other (if yes please specify _____)... | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

***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 |

***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 |

***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 |

***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 |

***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 |

***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 | |

***DOMESTIC ABUSE VICTIM/SURVIVOR**

| | | | | |
|---|--|--|--|---|
| <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: WHEN EXPERIENCE OCCURRED | | | | |
| <input type="checkbox"/> Within the past 3 months | <input type="checkbox"/> 3 to 6 months ago | <input type="checkbox"/> From 6 to 12 months ago | Are you currently fleeing? | |
| <input type="checkbox"/> More than a year ago | <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Client Refused | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Data Not Collected | | | <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Client Refused |
| | | <input type="checkbox"/> Data Not Collected | | |

***ZIP CODE OF LAST PERMANENT ADDRESS**

| SERVICES SOUGHT | |
|---|---|
| <input type="checkbox"/> Has CDPHP Medicaid | <input type="checkbox"/> Does not have CDPHP Medicaid |

CRHMIS Client Informed Consent and Release of Information

_____ (agency name) _____ participates in the CARES Regional Homeless Management Information System (CRHMIS). This means that we collect information about your household and input it into a secure and private database that allows us to keep track of that information to better assess and serve your needs.

The CRHMIS is dedicated to the privacy and safeguarding of the information collected and input into the HMIS database and does not publish identifying, client level data. For more information, please see our complete policy and procedure manual, which includes information on opting out of the HMIS, data ownership and a list of research and coordination projects that use HMIS information at www.caresny.org/HMIS-policies.

To better assist in the coordination and provision of services, we are requesting your permission to share limited information about you with other homeless services providers. As the owner of your own information within the CRHMIS, you have the right to choose whether or not other users of the system can see any of your personal information and on what level. HIV/AIDS information, Domestic Violence information, Behavioral health (mental illness and substance abuse) and client notes are NOT shared through the HMIS. This consent will be in effect for a minimum of 36 months but may be revoked at any time.

Please check the (1) box below which indicates the level at which you are willing to share your information with the homeless services coordinators and providers in the community;

___ I agree to share my name, gender and program enrollment history through the HMIS with other provider homeless services agencies.

___ I agree to share my name, gender, program enrollment history, demographic, income and contact information through the HMIS with other partner homeless services agencies.

___ I do NOT agree to share any of my information through the HMIS with other partner homeless services agencies.

By signing this form, I agree to share the above level of information with other partner agencies via the HMIS Computer System:

PRINTED name of Client

Signature of Client, Guardian or Power of Attorney

Date

Signature of Witness

Date

INSTRUCTIONS:

- 1) These are two separate forms sharing one page for convenience and resource conservation.
- 2) A form must be filled out for EACH household member. Minors may NOT sign for themselves or their children, even if they are the head of household. The additional MINOR consent should be filled out and signed by a parent or guardian for all minors or adult household members with developmental disabilities which would preclude them from signing the consent themselves.

CRHMIS Inclusion Disclosure

The CRHMIS has moved from *inferred consent* (a posted sign) to an *inclusion disclosure* for the HMIS. **No consumer consent is required by the CRHMIS to enter consumer data.** This disclosure replaces the posted sign but fulfills the same purpose. Consumers are asked to initial that they received the information. This is in addition to any agency specific or CoC specific forms that may be presented upon intake.

While individual agencies and projects may have their own, overriding policies, refusing to initial the inclusion disclosure does **NOT** indicate a refusal to be included in the HMIS and does not automatically disqualify consumers from receiving services from the agency or project; agency and CoC policy regarding how to handle that situation should still be followed as it has been in past years.

CRHMIS Client Release of Information

The CRHMIS is not an open system and does not automatically share data between agencies. In order to better coordinate case care; however, the CRHMIS Advisory Committee has agreed to a stepped implementation of consumer-driven data sharing. If your project allows data sharing (please contact kclark@caresny.org if you are not sure) the consumer may choose to share some or most of their data within the HMIS. This data is shared only to other HMIS users who have been through training in the system and agreed to all privacy and security polices. Special needs (i.e. mental health, HIV status, substance abuse status) are NEVER Shared between agencies.

If your agency or project DOES NOT participate in data sharing, you must check option 3 on this sheet and have the consumer sign, indicating that they understand that their data will NOT be shared regardless of preference. When entering the intake into HMIS, "No Sharing" is the default and, in this circumstance will be left at the default and the intake processed. Monitoring will include checking to ensure that physical forms and HMIS records match.

If your agency and project DOES participate in data sharing, you must give the consumer the choice to share at level 1 (most restrictive but still shared), 2 (less restrictive) or 3 (no sharing at all). The consumer must then sign and date the form. Monitoring will include checking to ensure that physical forms and HMIS records match