CARES REGIONAL HMIS INTAKE – EMERGENCY SHELTER
Household Members Under 18

*INTAKE DATE	*BED/UNIT	PRIMARY WORKER
/ /		

*FIRST NAME	MIDDLE NAME	*LAST NAME (and Suffix)

*NAME DATA QUALITY	ALIAS
❑ Full Name Reported ❑ Partial Name, Street Name or Code Name Reported ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected	

*SOCIAL SECURITY NUMBER	*SSN DATA QUALITY
(enter "9" for any missing numbers in an Approximate or Partial SSN) ____ ____ ____ - ____ ____ - ____ ____ ____ ____	❑ Full SSN Reported ❑ Approximate or Partial SSN Reported ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

*GENDER

❑ Male ❑ Female ❑ Trans Male(FTM)
❑ Trans Female(MTF) ❑ Gender Non-Conforming
❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

*BIRTHDATE	*BIRTHDATE DATA QUALITY
_____/_____/_____	❑ Full DOB Reported ❑ Approximate or Partial DOB Reported ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

*ETHNICITY

❑ Hispanic ❑ Non-Hispanic ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

*RACE (choose all that apply)

❑ American Indian/Native Alaskan ❑ Black ❑ White
❑ Asian ❑ Native Hawaiian or Other Pacific Islander
❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

*COVERED BY HEALTH INSURANCE

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

IF YES:

MEDICAID	❑ No	❑ Yes	MEDICARE	❑ No	❑ Yes
State Children's Health Insurance Program	❑ No	❑ Yes	VA Medical Services	❑ No	❑ Yes
Employer provided Health insurance	❑ No	❑ Yes	Health ins. via COBRA	❑ No	❑ Yes
Private Pay Health Insurance	❑ No	❑ Yes	State Health Ins. Adults	❑ No	❑ Yes
Indian Health Services	❑ No	❑ Yes	Other (if yes please specify_____)	❑ No	❑ Yes

*PHYSICAL DISABILITY

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

IF YES:

Expected to substantially impair ability to live independently:

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

*DEVELOPMENTAL DISABILITY

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

IF YES:

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:

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

*CHRONIC HEALTH CONDITION

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

IF YES:

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:

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

*HIV/AIDS

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

IF YES:

Expected to substantially impair ability to live independently:

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

*MENTAL HEALTH

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

IF YES:

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:

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

*SUBSTANCE ABUSE PROBLEM

❑ Alcohol Abuse ❑ Drug Abuse ❑ Both Alcohol and Drug Abuse
❑ No ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

IF YES:

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:

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

SERVICES SOUGHT

❑ Shelter/Housing	❑ Drug Treatment	❑ Mental Health Care
❑ Medical Care	❑ Legal Aid - CRJS/Civil	❑ Legal Aid - Immigration

CRHMIS Client Release of Information

For Household Members Under the Age of 18 and Adults Who are Unable to Sign on Their Own

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;

1) ___ I agree to share my name, gender and program enrollment history through the HMIS with other provider homeless services agencies.
2) ___ I agree to share my name, gender, program enrollment history, demographic, income and contact information through the HMIS with other partner homeless services agencies.
3) ___ I do NOT agree to share any of my information through the HMIS with other partner homeless services agencies.

PRINTED NAMES OF ALL MINOR CHILDREN OR DEVELOPMENTALLY DISABLED HOUSEHOLD MEMBERS COVERED BY THIS AGREEMENT:

_____

_____

_____

_____

_____

_____

_____

_____

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

_____
Print name of Guardian or Power of Attorney

_____
Print name of Witness

_____
Signature of Client, Guardian or Power of Attorney

_____
Signature of Witness

_____
Date

_____
Date