HMIS INTAKE - HOPWA

INTAKE DATE	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 (i.e. not exclusively male or female)	
❑ 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

VETERAN STATUS				
❑ No	❑ Yes	❑ Client Doesn't Know	❑ Client Refused	❑ 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
❑ Place not meant for human habitation (vehicle, abandoned building, bus/train/subway station etc) ❑ Emergency shelter, including hotel or motel paid for with emergency shelter voucher ❑ Safe Haven ❑ Interim Housing	❑ 1 night or less ❑ 2 to 6 nights ❑ 1 week or more, but less than 1 month ❑ 1 month or more, but less than 90 days ❑ 90 days or more, but less than 1 year ❑ 1 year or longer ❑ Client Doesn't Know ❑ Client Refused ❑ 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:
_____/_____/_____	❑ 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

INSTITUTIONAL SITUATIONS:

TYPE OF RESIDENCE NIGHT BEFORE PROJECT ENTRY:	
❑ Foster care home or foster care group home ❑ Hospital or other residential 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 or detox center	Did you stay less than 90 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

TRANSITIONAL AND PERMANENT HOUSING SITUATIONS:

TYPE OF RESIDENCE NIGHT BEFORE PROJECT ENTRY:

❑ Hotel or Motel paid for without emergency voucher
❑ Owned by client, no ongoing subsidy
❑ Owned by client WITH ongoing subsidy
❑ Perm. Supportive housing for formerly homeless persons (CoC project, HUD legacy program, HOPWA)
❑ Rental by client, no ongoing subsidy
❑ Rental by client with GPD TIP subsidy
❑ Rental by client with VASH subsidy
❑ Rental by client with other ongoing housing subsidy
❑ Residential project or halfway house with no homeless criteria
❑ Staying or in a family member's room, apartment or house
❑ Staying or in a friend's room, apartment or house
❑ 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

*HAS CLIENT BEEN PLACED INTO PERMANET HOUSING	IF YES: DATE	RESIDENCE UNIT
❑ No ❑ Yes	_____/_____/_____	

INCOME FROM ANY SOURCE (monthly)

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

IF YES:

❑ Earned Income..... $_____
❑ SSI..... $_____
❑ VA Service-Connected Disability Compensation..... $_____
❑ Private Disability Insurance..... $_____
❑ TANF..... $_____
❑ Unemployment Insurance..... $_____
❑ SSDI..... $_____
❑ VA Non-Service Connected Disability Pension..... $_____
❑ Worker's Compensation..... $_____
❑ General Public Assistance..... $_____

❑ Retirement from SSA ..... $_____	❑ Pension or Retirement from former job .....$_____
❑ Child Support ..... $_____	❑ Alimony or Other Spousal Support .....$_____
❑ Other ..... $_____	

NON CASH BENEFITS FROM ANY SOURCE

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

IF YES:

❑ SNAP ❑ Special Supplemental Nutrition Program for Women, Infants and Children
❑ TANF Child Care Services ❑ TANF Transportation Services ❑ Other TANF Funded Srvcs
❑ Other Source

COVERED BY HEALTH INSURANCE

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

HEALTH INSURANCE	IF NO, REASON:
MEDICAID ❑ No ❑ Yes	❑ Applied: decision pending ❑ Applied: client not eligible ❑ Client did not apply ❑ Insurance type N/A for this client ❑ Client doesn't know ❑ Client refused ❑ Data not collected
MEDICARE ❑ No ❑ Yes	❑ Applied: decision pending ❑ Applied: client not eligible ❑ Client did not apply ❑ Insurance type N/A for this client ❑ Client doesn't know ❑ Client refused ❑ Data not collected
State Children's Health Insurance Program ❑ No ❑ Yes	❑ Applied: decision pending ❑ Applied: client not eligible ❑ Client did not apply ❑ Insurance type N/A for this client ❑ Client doesn't know ❑ Client refused ❑ Data not collected
Veteran's Administration (VA) Medical Services ❑ No ❑ Yes	❑ Applied: decision pending ❑ Applied: client not eligible ❑ Client did not apply ❑ Insurance type N/A for this client ❑ Client doesn't know ❑ Client refused ❑ Data not collected
Employer-Provided Health Insurance ❑ No ❑ Yes	❑ Applied: decision pending ❑ Applied: client not eligible ❑ Client did not apply ❑ Insurance type N/A for this client ❑ Client doesn't know ❑ Client refused ❑ Data not collected
Health Insurance acquired through COBRA ❑ No ❑ Yes	❑ Applied: decision pending ❑ Applied: client not eligible ❑ Client did not apply ❑ Insurance type N/A for this client ❑ Client doesn't know ❑ Client refused ❑ Data not collected
Private Pay Health Insurance ❑ No ❑ Yes	❑ Applied: decision pending ❑ Applied: client not eligible ❑ Client did not apply ❑ Insurance type N/A for this client ❑ Client doesn't know ❑ Client refused ❑ Data not collected
State Health Insurance for Adults ❑ No ❑ Yes	❑ Applied: decision pending ❑ Applied: client not eligible ❑ Client did not apply ❑ Insurance type N/A for this client ❑ Client doesn't know ❑ Client refused ❑ Data not collected
Indian Health Services ❑ No ❑ Yes	❑ Applied: decision pending ❑ Applied: client not eligible ❑ Client did not apply ❑ Insurance type N/A for this client ❑ Client doesn't know ❑ Client refused ❑ Data not collected
Other ❑ No ❑ Yes (specify: _____)	❑ Applied: decision pending ❑ Applied: client not eligible ❑ Client did not apply ❑ Insurance type N/A for this client ❑ Client doesn't know ❑ Client refused ❑ Data not collected

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

DOMESTIC ABUSE VICTIM/SURVIVOR

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

IF YES:

When Experience Occurred:

❑ Within the past 3 months ❑ Three to six months ago ❑ From six to twelve months ago ❑ More than a year ago

❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

Are you currently fleeing?

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

RECEIVING PUBLIC HIV/AIDS MEDICAL ASSISTANCE

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

IF NO, REASON:

❑ Applied: decision pending ❑ Applied: client not eligible ❑ Client did not apply ❑ Insurance type N/A for this client

❑ Client doesn't know ❑ Client refused ❑ Data not collected

RECEIVING AIDS DRUG ASSISTANCE PROGRAM (ADAP)

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

IF NO, REASON:

❑ Applied: decision pending ❑ Applied: client not eligible ❑ Client did not apply ❑ Insurance type N/A for this client

❑ Client doesn't know ❑ Client refused ❑ Data not collected

T-CELL (CD4) COUNT AVAILABLE

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

IF YES:

T-Cell Count: _____

How was the information obtained: ❑ Medical Report ❑ Client Report ❑ Other

VIRAL LOAD INFORMATION AVAILABLE

❑ Not available ❑ Available ❑ Undetectable ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

IF AVAILABLE:

Viral Load: _____

How was the information obtained: ❑ Medical Report ❑ Client Report ❑ Other

ZIP CODE OF LAST PERMANENT ADDRESS

SERVICES SOUGHT

❑ Client has CDPHP Managed Medicaid ❑ Client does not have CDPHP Managed Medicaid

❑ Client has completed CDPHP release form ❑ Client needs new medical insurance card

❑ Client requests contact from Nurse Case Manager ❑ CDPHP Member Services contacted 518-641-3466

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 Signature of Witness

_____ _____

Date 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 polies. 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