

# CARES REGIONAL HMIS INTAKE – RHY BASIC CENTER PROGRAM 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	SSN DATA QUALITY
(enter "9" for any missing numbers in an Approximate or Partial SSN)  ____-____-____	<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

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

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

*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:				
<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

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:				
<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

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:				
<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

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:				
<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

SUBSTANCE ABUSE PROBLEM				
<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Both Alcohol and Drug Abuse		<input type="checkbox"/> Data Not Collected
<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused		

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

DISABLING 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

<b>RHY-BCP STATUS</b>	
YOUTH ELIGIBLE FOR RHY SERVICES	(IF NO) REASON FOR NOT PROVIDING SERVICES
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Out of age range <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 DUE DATE
<input type="checkbox"/> No <input type="checkbox"/> Yes	____/____/____

<b>FORMERLY A WARD OF CHILD WELFARE OR FOSTER CARE AGENCY</b>	<b>IF YES</b>	<b>IF LESS THAN 1 YEAR: NUMBER OF 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	<input type="checkbox"/> Less than 1 year <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 3 to 5 or more 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
<b>FORMERLY A WARD OF THE JUVENILE JUSTICE SYSTEM</b>	<b>IF YES</b>	<b>IF LESS THAN 1 YEAR: NUMBER OF 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	<input type="checkbox"/> Less than 1 year <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 3 to 5 or more 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

<b>YOUNG PERSON'S CRITICAL ISSUES</b>		
<input type="checkbox"/> Unemployment - Family member <input type="checkbox"/> Alcohol or other drug abuse - Family member	<input type="checkbox"/> Mental Health Issues - Family member <input type="checkbox"/> Insufficient Income to support youth - Family member	<input type="checkbox"/> Physical Disability - Family member <input type="checkbox"/> Incarcerated Parent of Youth

<b>RHY REFERRAL SOURCE</b>		
<input type="checkbox"/> Self-Referral <input type="checkbox"/> Residential Project <input type="checkbox"/> Mental Hospital	<input type="checkbox"/> Individual: Parent/Guardian/Relative/Friend/Other <input type="checkbox"/> Hotline <input type="checkbox"/> School	<input type="checkbox"/> Child Welfare/CPS <input type="checkbox"/> Other Organization
<input type="checkbox"/> Outreach Project <input type="checkbox"/> Juvenile Justice <input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Temporary Shelter <input type="checkbox"/> Law Enforcement/Police <input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected

<b>NUMBER OF TIMES APPROACHED BY OUTREACH PRIOR TO ENTERING THE PROJECT</b>	<b>ZIP CODE OF LAST PERMANENT ADDRESS</b>
_____	_____

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