

CARES REGIONAL HMIS Intake – RHY Street Outreach

INTAKE DATE	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

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				
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<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

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

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

CURRENTLY PREGNANT	IF YES DUE DATE
<input type="checkbox"/> No <input type="checkbox"/> Yes	____/____/____

ZIP CODE OF LAST PERMANENT ADDR	ENGAGEMENT DATE
_____	____/____/____

CONTACT DATE	LOCATION	STAYING ON STREETS, ES OR SH
____/____/____		<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Worker Unable to Determine

OUTREACH WORKER	REASON FOR ENCOUNTER	BEHAVIORAL INDICATORS
	<input type="checkbox"/> Crisis Intervention <input type="checkbox"/> Follow Up <input type="checkbox"/> Hospital Referral <input type="checkbox"/> Outreach Activity <input type="checkbox"/> Police Referral <input type="checkbox"/> Soc Serv Referral <input type="checkbox"/> Phone Referral <input type="checkbox"/> Walk-in <input type="checkbox"/> Weather Intervention	<input type="checkbox"/> Alcohol Prob <input type="checkbox"/> Behavioral Prob <input type="checkbox"/> Bizarre Behavior <input type="checkbox"/> Depression <input type="checkbox"/> Drug Prob <input type="checkbox"/> Homicidal <input type="checkbox"/> Physically Ill <input type="checkbox"/> Prob with Aging <input type="checkbox"/> Suicidal <input type="checkbox"/> Other:

REFERRALS MADE	SERVICES ACCEPTED BY CLIENT
<input type="checkbox"/> Alcohol Detox <input type="checkbox"/> Alcohol Treatment <input type="checkbox"/> Shelter <input type="checkbox"/> Drop-in Center <input type="checkbox"/> Drug Detox <input type="checkbox"/> Drug Treatment <input type="checkbox"/> Entitlements <input type="checkbox"/> Medical Attention <input type="checkbox"/> Private Shelter <input type="checkbox"/> Psych Eval <input type="checkbox"/> Showers <input type="checkbox"/> Food Pantry <input type="checkbox"/> Other: _____	Assessment <input type="checkbox"/> Not Offered <input type="checkbox"/> Accepted <input type="checkbox"/> Refused Clothing <input type="checkbox"/> Not Offered <input type="checkbox"/> Accepted <input type="checkbox"/> Refused Transportation <input type="checkbox"/> Not Offered <input type="checkbox"/> Accepted <input type="checkbox"/> Refused Food/Showers <input type="checkbox"/> Not Offered <input type="checkbox"/> Accepted <input type="checkbox"/> Refused Information/Counseling <input type="checkbox"/> Not Offered <input type="checkbox"/> Accepted <input type="checkbox"/> Refused Other <input type="checkbox"/> Not Offered <input type="checkbox"/> Accepted <input type="checkbox"/> Refused

ENCOUNTER NOTES