cares
ENDING HOMELESSNESS

2018 HMIS INTAKE
HHS: PATH – Services Only
All Clients

*INTAKE DATE	PRIMARY WORKER (CASE WORKER)
_____/_____/_____	

*FIRST NAME	MIDDLE NAME	*LAST NAME & 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 approx. or partial SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___	❑ Full SSN Reported ❑ Approximate or Partial SSN Reported	❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

*GENDER

❑ Female ❑ Male	❑ Trans Female (MTF or Male to Female) ❑ Trans Male (FTM or Female to Male)	❑ Gender Non-Conforming (Doesn't identify as male, female, or transgendered)	❑ *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

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

*RACE: CHECK ALL THAT APPLY

❑ American Indian or Native Alaskan ❑ Black or African American ❑ 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 only one (1) section:
Homeless Situation, Institutional Situation, Transitional/Permanent Situation, **OR** Unknown (**only** if necessary).

HOMELESS SITUATIONS

*TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)	*LENGTH OF STAY IN PREVIOUS PLACE	
❑ **Place not meant for human habitation** (e.g. a vehicle, abandoned building, bus/train/subway station/airport or anywhere outside) ❑ **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

_____/_____/_____

*(REGARDLESS OF WHERE THEY STAYED LAST NIGHT) NUMBER OF TIMES ON THE STREETS, IN ES, OR SH IN THE PAST THREE YEARS (INCLUDING TODAY)		*TOTAL NUMBER OF MONTHS HOMELESS ON THE STREETS, IN ES, OR SH IN THE PAST THREE YEARS	
❑ 1 ❑ 2 ❑ 3 ❑ 4+	❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12 ❑ Over 12	❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

OR

----- GO ON -----

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INSTITUTIONAL SITUATIONS

*TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)	*LENGTH OF STAY IN PREVIOUS PLACE	
❏ **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	❏ 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*

*DID THE CLIENT STAY LESS THAN 7 DAYS?	IF YES: THE NIGHT BEFORE THAT, DID THEY STAY ON THE STREETS, IN ES, OR SH?
❏ No ❏ Yes (SEE RIGHT)	❏ No ❏ Yes (SEE BELOW)

IF YES TO [ON THE NIGHT BEFORE THAT, WERE THEY ON THE STREETS, IN ES, OR SH?]: PROVIDE DETAILS OF PREVIOUS HOMELESSNESS

*APPROXIMATE DATE HOMELESSNESS STARTED

_____/_____/_____

*(REGARDLESS OF WHERE THEY STAYED LAST NIGHT) **NUMBER OF TIMES** ON THE STREETS, IN ES, OR SH IN THE PAST THREE YEARS (INCLUDING TODAY)		***TOTAL NUMBER OF MONTHS HOMELESS** ON THE STREETS, IN ES, OR SH IN THE PAST THREE YEARS	
❏ 1 ❏ 2 ❏ 3 ❏ 4+	❏ *Client Doesn't Know* ❏ *Client Refused* ❏ *Data Not Collected*	❏ 1 ❏ 2 ❏ 3 ❏ 4 ❏ 5 ❏ 6 ❏ 7 ❏ 8 ❏ 9 ❏ 10 ❏ 11 ❏ 12 ❏ Over 12	❏ *Client Doesn't Know* ❏ *Client Refused* ❏ *Data Not Collected*

OR

TRANSITIONAL AND PERMANENT HOUSING SITUATIONS

*TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)		*LENGTH OF STAY IN PREVIOUS PLACE
❏ **Hotel or motel** paid for **without** emergency shelter voucher ❏ Owned by client, **no** ongoing subsidy ❏ Owned by client, **with** ongoing subsidy ❏ **Permanent housing (other than RRH)** for formerly homeless persons (PSH, 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 housing subsidy (**including RRH**) ❏ Residential project or halfway house with no homeless criteria ❏ **Staying or living in family** member's room, apartment, or house ❏ **Staying or living in friend's** room, apartment, or house ❏ **Transitional housing** for homeless persons (including homeless youth)	❏ 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*

*DID THE CLIENT STAY LESS THAN 90 DAYS?	IF YES: THE NIGHT BEFORE THAT, DID THEY STAY ON THE STREETS, IN ES, OR SH?
❏ No ❏ Yes (SEE RIGHT)	❏ No ❏ Yes (SEE BELOW)

IF YES TO [ON THE NIGHT BEFORE THAT, WERE THEY ON THE STREETS, IN ES, OR SH?]: PROVIDE DETAILS OF PREVIOUS HOMELESSNESS

*APPROXIMATE DATE HOMELESSNESS STARTED

_____/_____/_____

*(REGARDLESS OF WHERE THEY STAYED LAST NIGHT) **NUMBER OF TIMES** ON THE STREETS, IN ES, OR SH IN THE PAST THREE YEARS (INCLUDING TODAY)		***TOTAL NUMBER OF MONTHS HOMELESS** ON THE STREETS, IN ES, OR SH IN THE PAST THREE YEARS	
❏ 1 ❏ 2 ❏ 3 ❏ 4+	❏ *Client Doesn't Know* ❏ *Client Refused* ❏ *Data Not Collected*	❏ 1 ❏ 2 ❏ 3 ❏ 4 ❏ 5 ❏ 6 ❏ 7 ❏ 8 ❏ 9 ❏ 10 ❏ 11 ❏ 12 ❏ Over 12	❏ *Client Doesn't Know* ❏ *Client Refused* ❏ *Data Not Collected*

OR

UNKNOWN (ONLY IF NECESSARY)

TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)

❏ *Client Doesn't Know*	❏ *Client Refused*	❏ *Data Not Collected*

----- GO ON -----

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*INCOME & SOURCES / NON-CASH BENEFITS

*INCOME FROM ANY SOURCE
❑ No ❑ Yes (SEE BELOW) ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*
IF YES: CHECK & FILL IN **MONTHLY AMOUNT** FOR ALL THAT APPLY

❑ Earned Income (i.e. employment income) .... $_____	❑ Unemployment Insurance .... $_____
❑ Supplemental Security Income (SSI) .... $_____	❑ Social Security Disability Insurance (SSDI) .... $_____
❑ VA Service-Connected Disability Compensation .... $_____	❑ VA Non-Service Connected Disability Pension .... $_____
❑ Private Disability Insurance .... $_____	❑ Worker's Compensation .... $_____
❑ Temporary Assistance for Needy Families (TANF) ... $_____	❑ General Assistance (GA) .... $_____
❑ Retirement Income from Social Security .... $_____	❑ Pension or Retirement Income from Former Job . $_____
❑ Child Support .... $_____	❑ Alimony and Other Spousal Support .... $_____

*NON-CASH BENEFITS FROM ANY SOURCE
❑ No ❑ Yes (SEE BELOW) ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*
IF YES: CHECK ALL THAT APPLY

❑ SNAP (Food Stamps)	❑ Special Supplemental Nutrition Program for Women, Infants, and Children	
❑ TANF Child Care Services	❑ TANF Transportation Services	❑ Other TANF-Funded Services

*HEALTH INSURANCE / DISABLING CONDITIONS

*COVERED BY HEALTH INSURANCE
❑ No ❑ Yes (SEE BELOW) ❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*
IF YES: CHECK ALL THAT APPLY

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 Insurance through COBRA .... ❑ No ❑ Yes
Private Pay Health Insurance .... ❑ No ❑ Yes	State Health Insurance for Adults .... ❑ No ❑ Yes
Indian Health Services Program .... ❑ No ❑ Yes	

*PHYSICAL DISABILITY		IF YES: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?	
❑ No ❑ Yes (SEE RIGHT)	❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes	❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*
*DEVELOPMENTAL DISABILITY		IF YES: EXPECTED TO SUBSTANTIALLY IMPAIR ABILITY TO LIVE INDEPENDENTLY?	
❑ No ❑ Yes (SEE RIGHT)	❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes	❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*
*CHRONIC HEALTH CONDITION		IF YES: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?	
❑ No ❑ Yes (SEE RIGHT)	❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes	❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*
*HIV/AIDS		IF YES: EXPECTED TO SUBSTANTIALLY IMPAIR ABILITY TO LIVE INDEPENDENTLY?	
❑ No ❑ Yes (SEE RIGHT)	❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes	❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*
*MENTAL HEALTH PROBLEM		IF YES: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?	
❑ No ❑ Yes (SEE RIGHT)	❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes	❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*
*SUBSTANCE ABUSE PROBLEM		IF YES: EXPECTED TO BE OF LONG-CONTINUED & INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?	
❑ No ❑ Yes, Alcohol (SEE RIGHT) ❑ Yes, Drug (SEE RIGHT) ❑ Yes, Both (SEE RIGHT)	❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*	❑ No ❑ Yes	❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

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

----- GO ON -----

*DATE OF ENGAGEMENT

*ENGAGEMENT DATE	
Leave blank until the client actively engages in the program. The date on which an interactive client relationship results in a deliberate client assessment or beginning of a case plan.	_____/_____/_____

*PATH-SPECIFIC INFORMATION

PATH STATUS		
*DATE OF STATUS DETERMINATION	*CLIENT BECAME ENROLLED IN PATH	**IF NO**: REASON NOT ENROLLED
_____/_____/_____	❑ No (SEE RIGHT) ❑ Yes	❑ Client was found ineligible for PATH ❑ Client was not enrolled for other reason(s)

*CONNECTION WITH SOAR	
❑ No ❑ Yes	❑ *Client Doesn't Know* ❑ *Client Refused* ❑ *Data Not Collected*

*NON-HMIS DATA ELEMENTS

*ZIP CODE OF LAST PERMANENT ADDRESS
_____ _____ _____ _____ _____

--- END ---

PROCEED TO CLIENT RELEASE OF INFORMATION

CRHMIS CLIENT INFORMED CONSENT & RELEASE OF INFORMATION

_____*(agency name)*_____ participates in the CARES Regional Homeless Management Information System (CRHMIS). This means that in addition to any agency or Continuum of Care (CoC) forms that may be presented upon intake, information about you and your household is collected into a private and secure computer database; this information is then used to better assess and serve your needs. **No consumer consent is required to enter consumer data into the HMIS system**.

CARES, Inc. (CARES) is dedicated to the protection of the information within the CRHMIS database. CARES does NOT publish identifying, client-level data. Further information can be found at **www.caresny.org/HMIS/** in our complete policy and procedure manual (including information on opting-out of the CRHMIS, data ownership, and a list of research and coordination projects that use CRHMIS information).

_____ **Please initial to indicate that you have read and understand the above information.**

To better support the coordination and provision of your services, we are requesting your permission to share a limited amount of information about you with other homeless services providers. As owner of your own data within the CRHMIS, you have the right to choose how much personal information, if any, is shared within the database. This permission will be in effect for a minimum of 36 months, but you may revoke consent at any time. HIV/AIDS information, Domestic Violence information, Behavioral Health information (including mental illness and substance abuse), and client notes are NOT shared through the HMIS.

Please check one (1) box below to indicate 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 partner 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 level of information indicated above with other partner agencies via the HMIS Computer System:

_____   _____
PRINT name of Client   PRINT name of Witness

_____   _____
SIGNATURE of Client, Guardian, or Power of Attorney   SIGNATURE of Witness

_____   _____
DATE   DATE

INSTRUCTIONS: Informed Consent & Release of Information

a) These are two (2) separate forms that share one (1) page and one (1) signature for resource conservation and client convenience.

b) One (1) form must be completed and signed by EACH adult household member.

    a. Minors may NOT sign for themselves or their children, even if they are the head of household.

There is a SEPARATE form for minors and adults unable to sign for themselves. This must be completed and signed by a parent or guardian for all minors and for all adult household members with developmental disabilities that would preclude them from signing a consent themselves.

CRHMIS Inclusion Disclosure

The CRHMIS has replaced *inferred consent* (a posted sign) with an *inclusion disclosure* (top part of reverse side) for the HMIS. They serve the same purpose.

No consumer consent is required by the CRHMIS to enter consumer data, in addition to any agency specific or CoC specific forms that may be presented upon intake. Consumers are asked to initial that they received the information.

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. In the event of a consumer refusal, agency and CoC policy regarding these situations should be followed.

CRHMIS Client Release of Information

The CRHMIS is not an open system and does not automatically share data between agencies. However, to better coordinate case care, the CRHMIS Advisory Committee has agreed to a stepped implementation of consumer-driven data sharing.

If an agency or project allows data sharing (please contact kclark@caresny.org if you are not sure), a consumer may choose to share some or most of their data within the CRHMIS. This data is only shared with other CRHMIS users who have been trained in the system and have agreed to all privacy and security policies. Special conditions (i.e. mental health, HIV status, substance abuse status) are NEVER shared between agencies. Monitoring of agencies will include checking to ensure that physical forms and CRHMIS records match.

a) *If your agency or project **DOES NOT** participate in data sharing, you must check **option 3** on this sheet and have the consumer sign and date the form, indicating that they understand that their data will NOT be shared, regardless of preference.*

    a. When entering the intake into the CRHMIS, "No Sharing" is the default and should not be changed.

b) *If your agency or 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.*