2018 HMIS INTAKE
HUD: CoC – Rapid Re-Housing
Minor in Household (Under 18)

*INTAKE DATE	PRIMARY WORKER (CASE WORKER)	
_____/_____/_____		
*FIRST NAME	MIDDLE NAME	*LAST NAME & SUFFIX

*NAME DATA QUALITY

❑ Full Name Reported
❑ Partial Name, Street Name, or Code Name Reported

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

ALIAS

*SOCIAL SECURITY NUMBER

(Enter "9" for any missing numbers in an approx. or partial SSN)
___ ___ ___ - ___ ___ - ___ ___ ___ ___

*SSN DATA QUALITY

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

*RESIDENCE SITUATION

*HAS CLIENT BEEN PLACED INTO PERMANENT HOUSING?	**IF YES**: MOVE IN DATE	**IF YES**: BED/UNIT
❑ No ❑ Yes (SEE RIGHT)	_____/_____/_____	

*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*

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

*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*

*NON-HMIS DATA ELEMENTS

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

--- END ---

PROCEED TO CLIENT RELEASE OF INFORMATION

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 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.

Print the names of all minor and/or developmentally disabled household members covered by this agreement:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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 Guardian or Power of Attorney	PRINT name of Witness
_____	_____
SIGNATURE of Guardian or Power of Attorney	SIGNATURE of Witness
_____	_____
DATE	DATE