





INSTITUTIONAL SITUATIONS	
*TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)	*LENGTH OF STAY IN PREVIOUS PLACE
<input type="checkbox"/> <b>Foster</b> care home or foster care group home <input type="checkbox"/> <b>Hospital</b> or other residential non-psychiatric medical facility <input type="checkbox"/> <b>Jail</b> , prison, or juvenile detention facility <input type="checkbox"/> <b>Long-term care</b> facility or <b>nursing home</b> <input type="checkbox"/> <b>Psychiatric hospital</b> or other psychiatric facility <input type="checkbox"/> <b>Substance abuse treatment</b> facility or detox center	<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"/> <i>Client Doesn't Know</i> <input type="checkbox"/> <i>Client Refused</i> <input type="checkbox"/> <i>Data Not Collected</i>	
*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
<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4+	<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"/> Over 12
<input type="checkbox"/> <i>Client Doesn't Know</i> <input type="checkbox"/> <i>Client Refused</i> <input type="checkbox"/> <i>Data Not Collected</i>	<input type="checkbox"/> <i>Client Doesn't Know</i> <input type="checkbox"/> <i>Client Refused</i> <input type="checkbox"/> <i>Data Not Collected</i>

OR

TRANSITIONAL AND PERMANENT HOUSING SITUATIONS	
*TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)	*LENGTH OF STAY IN PREVIOUS PLACE
<input type="checkbox"/> <b>Hotel or motel</b> paid for <b>without</b> emergency shelter voucher <input type="checkbox"/> Owned by client, <b>no</b> ongoing subsidy <input type="checkbox"/> Owned by client, <b>with</b> ongoing subsidy <input type="checkbox"/> <b>Permanent housing (other than RRH)</b> for formerly homeless persons (PSH, HOPWA) <input type="checkbox"/> Rental by client, <b>no</b> ongoing subsidy <input type="checkbox"/> Rental by client, with GPD TIP subsidy <input type="checkbox"/> Rental by client, with VASH subsidy	<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"/> Rental by client, with other housing subsidy ( <b>including RRH</b> ) <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> <b>Staying or living in family member's</b> room, apartment, or house <input type="checkbox"/> <b>Staying or living in friend's</b> room, apartment, or house <input type="checkbox"/> <b>Transitional housing</b> for homeless persons (including homeless youth)	<input type="checkbox"/> <i>Client Doesn't Know</i> <input type="checkbox"/> <i>Client Refused</i> <input type="checkbox"/> <i>Data Not Collected</i>
*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
<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4+	<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"/> Over 12
<input type="checkbox"/> <i>Client Doesn't Know</i> <input type="checkbox"/> <i>Client Refused</i> <input type="checkbox"/> <i>Data Not Collected</i>	<input type="checkbox"/> <i>Client Doesn't Know</i> <input type="checkbox"/> <i>Client Refused</i> <input type="checkbox"/> <i>Data Not Collected</i>

OR

UNKNOWN (ONLY IF NECESSARY)
TYPE OF RESIDENCE (THE NIGHT BEFORE PROJECT ENTRY)
<input type="checkbox"/> <i>Client Doesn't Know</i> <input type="checkbox"/> <i>Client Refused</i> <input type="checkbox"/> <i>Data Not Collected</i>

**\*INCOME & SOURCES / NON-CASH BENEFITS**

*INCOME FROM ANY SOURCE	
<input type="checkbox"/> No <input type="checkbox"/> Yes (SEE BELOW)	<input type="checkbox"/> <i>Client Doesn't Know</i> <input type="checkbox"/> <i>Client Refused</i> <input type="checkbox"/> <i>Data Not Collected</i>
IF YES: CHECK & FILL IN MONTHLY AMOUNT FOR ALL THAT APPLY	
<input type="checkbox"/> Earned Income (i.e. employment income) ..... \$ _____ <input type="checkbox"/> Supplemental Security Income (SSI).....\$ _____ <input type="checkbox"/> VA Service-Connected Disability Compensation ..... \$ _____ <input type="checkbox"/> Private Disability Insurance .....\$ _____ <input type="checkbox"/> Temporary Assistance for Needy Families (TANF) ...\$ _____ <input type="checkbox"/> Retirement Income from Social Security .....\$ _____ <input type="checkbox"/> Child Support.....\$ _____	<input type="checkbox"/> Unemployment Insurance ..... \$ _____ <input type="checkbox"/> Social Security Disability Insurance (SSDI)..... \$ _____ <input type="checkbox"/> VA Non-Service Connected Disability Pension .... \$ _____ <input type="checkbox"/> Worker's Compensation ..... \$ _____ <input type="checkbox"/> General Assistance (GA) ..... \$ _____ <input type="checkbox"/> Pension or Retirement Income from Former Job . \$ _____ <input type="checkbox"/> Alimony and Other Spousal Support..... \$ _____

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



<b>*NON-CASH BENEFITS FROM ANY SOURCE</b>	
<input type="checkbox"/> No <input type="checkbox"/> Yes (SEE BELOW) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	
<b>IF YES: CHECK ALL THAT APPLY</b>	
<input type="checkbox"/> SNAP (Food Stamps) <input type="checkbox"/> TANF Child Care Services	<input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children <input type="checkbox"/> TANF Transportation Services <input type="checkbox"/> Other TANF-Funded Services

**\*HEALTH INSURANCE / DISABLING CONDITIONS**

<b>*COVERED BY HEALTH INSURANCE</b>	
<input type="checkbox"/> No <input type="checkbox"/> Yes (SEE BELOW) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	
<b>IF YES: CHECK ALL THAT APPLY</b>	
MEDICAID ..... <input type="checkbox"/> No <input type="checkbox"/> Yes State Children's Health Insurance Program..... <input type="checkbox"/> No <input type="checkbox"/> Yes Employer-Provided Health Insurance ..... <input type="checkbox"/> No <input type="checkbox"/> Yes Private Pay Health Insurance ..... <input type="checkbox"/> No <input type="checkbox"/> Yes Indian Health Services Program ..... <input type="checkbox"/> No <input type="checkbox"/> Yes	MEDICARE ..... <input type="checkbox"/> No <input type="checkbox"/> Yes VA Medical Services ..... <input type="checkbox"/> No <input type="checkbox"/> Yes Health Insurance through COBRA ..... <input type="checkbox"/> No <input type="checkbox"/> Yes State Health Insurance for Adults..... <input type="checkbox"/> No <input type="checkbox"/> Yes
<b>*PHYSICAL DISABILITY</b>	<b>IF YES: EXPECTED TO BE OF LONG-CONTINUED &amp; INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?</b>
<input type="checkbox"/> No <input type="checkbox"/> Yes (SEE RIGHT) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<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>*DEVELOPMENTAL DISABILITY</b>	<b>IF YES: EXPECTED TO SUBSTANTIALLY IMPAIR ABILITY TO LIVE INDEPENDENTLY?</b>
<input type="checkbox"/> No <input type="checkbox"/> Yes (SEE RIGHT) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<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>*CHRONIC HEALTH CONDITION</b>	<b>IF YES: EXPECTED TO BE OF LONG-CONTINUED &amp; INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?</b>
<input type="checkbox"/> No <input type="checkbox"/> Yes (SEE RIGHT) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<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>*HIV/AIDS</b>	<b>IF YES: EXPECTED TO SUBSTANTIALLY IMPAIR ABILITY TO LIVE INDEPENDENTLY?</b>
<input type="checkbox"/> No <input type="checkbox"/> Yes (SEE RIGHT) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<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>*MENTAL HEALTH PROBLEM</b>	<b>IF YES: EXPECTED TO BE OF LONG-CONTINUED &amp; INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?</b>
<input type="checkbox"/> No <input type="checkbox"/> Yes (SEE RIGHT) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<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>*SUBSTANCE ABUSE PROBLEM</b>	<b>IF YES: EXPECTED TO BE OF LONG-CONTINUED &amp; INDEFINITE DURATION AND SUBSTANTIALLY IMPAIRS ABILITY TO LIVE INDEPENDENTLY?</b>
<input type="checkbox"/> No <input type="checkbox"/> Yes, Alcohol (SEE RIGHT) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Yes, Drug (SEE RIGHT) <input type="checkbox"/> Client Refused <input type="checkbox"/> Yes, Both (SEE RIGHT) <input type="checkbox"/> Data Not Collected	<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

**\*DV STATUS**

<b>*DOMESTIC ABUSE VICTIM/SURVIVOR</b>	
<input type="checkbox"/> No <input type="checkbox"/> Yes (SEE BELOW) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	
<b>IF YES: WHEN EXPERIENCE OCCURRED</b>	<b>IF YES: ARE YOU CURRENTLY FLEEING?</b>
<input type="checkbox"/> Within the past 3 months <input type="checkbox"/> 6 months to 1 year ago <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> 3 to 6 months ago <input type="checkbox"/> 1 year ago or more <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<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

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



**\*NON-HMIS DATA ELEMENTS**

*ZIP CODE OF LAST PERMANENT ADDRESS	
_____	
SERVICES SOUGHT	
<input type="checkbox"/> Client has CDPHP Managed Medicaid	<input type="checkbox"/> Client does not have CDPHP Managed Medicaid

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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/](http://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.

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*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.*

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### *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](mailto: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.*