

2018.03 ENDING HOMELESSNESS \* = DATA IS REQUIRED

2018 HMIS INTAKE HUD: HOPWA – Permanent Housing Minor in Household (Under 18)						
*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 D	ATA QUALITY			
			SSN Reported roximate or Partial	SSN Re	ported	☐ Client Doesn't Know☐ Client Refused☐ Data Not Collected☐
*GENDER						
☐ Female ☐ Trans Female (MTF or Male to Female) ☐ Gender Non-Conforming (Doesn't iden male, female, or transgendered) ☐ Gender Non-Conforming (Doesn't iden male, female, or transgendered)			n't identify as	☐ Client Doesn't Know☐ Client Refused☐ Data Not Collected☐		
*BIRTHDATE *BIRTHDATI	E DATA QUALIT	Υ				
Full DOB Reported Approximate or Partial DOB			ported			<ul><li>□ Client Doesn't Know</li><li>□ Client Refused</li><li>□ Data Not Collected</li></ul>
*ETHNICITY						
☐ Non-Hispanic/Non-Latino ☐ H	ispanic/Latino			Client Does	sn't Know 🛭 Client Refus	ed 🗖 Data Not Collected
*RACE: CHECK ALL THAT APPLY						
□ American Indian or Native Alaskan □ Black or African American □ Native Hawaiian or Other Pacific Islander □ White □ Client Doesn't Know □ Client Refused □ Data Not Collected						
	*RESI	DENCE	SITUATION			
*HAS CLIENT BEEN PLACED INTO PERMANENT HOUSING? IF YES: MOVE IN DATE IF YES: BED/UNIT						
□ No □ Yes (SEE RIGHT)			/ /			
					1	
*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						
MEDICAIDState Children's Health Insurance Program.						
Employer-Provided Health Insurance	□ No	Yes	Health Insuran	ce throug	gh COBRA	□ No □ Yes
Private Pay Health InsuranceIndian Health Services Program			State Health In	surance	for Adults	□ No □ Yes
*PHYSICAL DISABILITY					LONG-CONTINUED & IN B ABILITY TO LIVE INDEF	
□ No □ Yes (SEE RIGHT)	☐ Client Does ☐ Client Refus ☐ Data Not Co	sed	□ 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 Does ☐ Client Refus ☐ Data Not Co	sed	□ No □	Yes		☐ Client Doesn't Know☐ Client Refused☐ Data Not Collected



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*CHRONIC HE	EALTH CONDITION			TED TO BE OF LONG-CONTINUED & INI FIALLY IMPAIRS ABILITY TO LIVE INDEP	
□ 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: EXPECTINDEPENDENTL	TED TO SUBSTANTIALLY IMPAIR ABILIT LY?	TY TO LIVE
□ 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	
☐ Client has CDPHP Managed Medicaid	☐ Client does not have CDPHP Managed Medicaid

--- 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 co	ommunity:
I agree to share my name, gender, and program en	rollment history through the HMIS with other partner homeless
services agencies.	
	nent 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 thro	ough the HMIS with other partner homeless services agencies.
	or and/or developmentally disabled
household members	s covered by this agreement:
By signing this form, I agree to share the level of info	rmation indicated above with other partner agencies via the
HMIS Computer System:	
DDINT name of Cuardian or Dower of Attorney	PRINT name of Witness
PRINT name of Guardian or Power of Attorney	PRINT Hame of Witness
SIGNATURE of Guardian or Power of Attorney	SIGNATURE of Witness

DATE

DATE