

2019 CARES REGIONAL HMIS

HUD:ESG/STEHP – Emergency Shelter – INTAKE



Instructions: Fill out one form per client at project entry, after completion of the CRHMIS Client Inclusion Disclosure & Release of Information.

***UNIVERSAL DATA ELEMENTS – REQUIRED for ALL Clients**

1. *INTAKE DATE ____/____/____		2. PRIMARY WORKER (CASE WORKER)	
3. *FIRST NAME		4. MIDDLE NAME	
5. *LAST NAME & SUFFIX			
6. *NAME DATA QUALITY <input type="checkbox"/> Full Name Reported <input type="checkbox"/> Partial Name, Street Name, or Code Name Reported		7. ALIAS <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Collected	
8. *SOCIAL SECURITY NUMBER (Enter "9" for any missing numbers in an approx. or partial SSN) ____ - ____ - ____		9. *SSN DATA QUALITY <input type="checkbox"/> Full SSN Reported <input type="checkbox"/> Approximate or Partial SSN Reported <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Collected	
10. *GENDER <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Trans Female (MTF or Male to Female) <input type="checkbox"/> Trans Male (FTM or Female to Male) <input type="checkbox"/> Gender Non-Conforming (Doesn't identify as male, female, or transgendered) <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Collected			
11. *BIRTHDATE ____/____/____		12. *BIRTHDATE DATA QUALITY <input type="checkbox"/> Full DOB Reported <input type="checkbox"/> Approximate or Partial DOB Reported <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Collected	
13. *ETHNICITY <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Collected			
14. *RACE – CHECK ALL THAT APPLY <input type="checkbox"/> American Indian or Native Alaskan <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Collected			
15. *PHONE NUMBER: Does the client have a phone number at which they can be reached? <input type="checkbox"/> No <input type="checkbox"/> Yes → 15A. PROVIDE # WITH AREA CODE (____) - ____ - ____ OR <input type="checkbox"/> Refused to provide phone number			
16. *VETERAN STATUS <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused <input type="checkbox"/> Not Collected			

***PRIOR LIVING SITUATION – Clients Over 18 & Heads of Household**

17. ***LOCATION THE NIGHT BEFORE PROJECT ENTRY:** Where did the client spend last night? – Select the category that most closely matches the client's response (does not need to be exact!)

HOMELESS SITUATIONS <input type="checkbox"/> Place not meant for habitation/'the streets' (Public or private places not intended for regular sleeping; e.g., a vehicle, abandoned building, bus/train station, airport, or anywhere outside) <input type="checkbox"/> Safe Haven <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher <input type="checkbox"/> Interim Housing	INSTITUTIONAL SITUATIONS <input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Jail, prison, or juvenile detention facility <input type="checkbox"/> Substance abuse treatment facility or detox center	TRANSITIONAL / PERMANENT HOUSING SITUATIONS <input type="checkbox"/> Rental by client, no ongoing subsidy <input type="checkbox"/> Rental by client, with GPD TIP subsidy <input type="checkbox"/> Rental by client, with VASH subsidy <input type="checkbox"/> Rental by client, with other housing subsidy (including RRH) <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons <input type="checkbox"/> Owned by client, no ongoing subsidy <input type="checkbox"/> Owned by client, with ongoing subsidy <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Staying/living in family member's room, apartment, or house <input type="checkbox"/> Staying/living in friend's room, apartment, or house <input type="checkbox"/> Transitional housing for homeless persons (incl. homeless youth)
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POOR/UNKNOWN DATA OPTIONS FOR PRIOR LIVING SITUATION – USE ONLY IF NECESSARY: Client Doesn't Know Client Refused Data Not Collected

18. ***LENGTH OF STAY IN PRIOR LOCATION:** How long had the client been staying where they spent last night?
 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

19. ***APPROXIMATE DATE CURRENT EPISODE OF HOMELESSNESS STARTED:** How long has the client been on the streets, in ES, or SH?
 ____/____/____

20. ***NUMBER OF TIMES HOMELESS (ON THE STREETS, IN ES, OR SH) IN THE PAST 3 YEARS** – If client came from a homeless situation, include today as 1 time
 1 2 3 4+

21. ***TOTAL NUMBER OF MONTHS HOMELESS (ON THE STREETS, IN ES, OR SH) IN THE PAST 3 YEARS** – Round to the month for each time and total
 1 2 3 4 5 6 7 8 9 10 11 12 Over 12 → 21A. TOTAL # OF MONTHS: ____

CONTINUE

***INCOME & BENEFITS – Clients Over 18 & Heads of Household**

22. *INCOME FROM ANY SOURCE		
<input type="checkbox"/> No <input type="checkbox"/> Yes → 23A. CHECK & PROVIDE MONTHLY AMOUNT FOR ALL SOURCES THAT APPLY BELOW □ Doesn't Know □ Refused □ Not Collected		
<input type="checkbox"/> Earned Income (i.e., employment pay)..... \$ _____	<input type="checkbox"/> Unemployment Insurance \$ _____	
<input type="checkbox"/> Supplemental Security Income (SSI) \$ _____	<input type="checkbox"/> Social Security Disability Insurance (SSDI) \$ _____	
<input type="checkbox"/> VA Service-Connected Disability Compensation \$ _____	<input type="checkbox"/> VA Non-Service Connected Disability Pension \$ _____	
<input type="checkbox"/> Private Disability Insurance \$ _____	<input type="checkbox"/> Worker's Compensation \$ _____	
<input type="checkbox"/> Temporary Assistance for Needy Families (TANF) \$ _____	<input type="checkbox"/> General Assistance (GA) \$ _____	
<input type="checkbox"/> Retirement Income from Social Security \$ _____	<input type="checkbox"/> Pension or Retirement Income from Former Job \$ _____	
<input type="checkbox"/> Child Support \$ _____	<input type="checkbox"/> Alimony and Other Spousal Support \$ _____	
23. *NON-CASH BENEFITS FROM ANY SOURCE		
<input type="checkbox"/> No <input type="checkbox"/> Yes → 24A. CHECK ALL SOURCES THAT APPLY BELOW □ Doesn't Know □ Refused □ Not Collected		
<input type="checkbox"/> SNAP (Food Stamps)	<input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	
<input type="checkbox"/> TANF Child Care Services	<input type="checkbox"/> TANF Transportation Services	<input type="checkbox"/> Other TANF-Funded Services

***HEALTH – All Clients**

24. *COVERED BY HEALTH INSURANCE		
<input type="checkbox"/> No <input type="checkbox"/> Yes → 25A. CHECK ALL SOURCES THAT APPLY BELOW □ Doesn't Know □ Refused □ Not Collected		
<input type="checkbox"/> MEDICAID	<input type="checkbox"/> MEDICARE	<input type="checkbox"/> State Children's Health Insurance Program
<input type="checkbox"/> VA Medical Services	<input type="checkbox"/> Employer-Provided Health Insurance	<input type="checkbox"/> Health Insurance through COBRA
<input type="checkbox"/> Private Pay Health Insurance	<input type="checkbox"/> State Health Insurance for Adults	<input type="checkbox"/> Indian Health Services Program
SPECIAL NEEDS – The following questions help determine if there are additional housing services or benefits available for the client. Select YES to DISABLING CONDITION IF (1) Expected to be of long, continued and indefinite duration, (2) Substantially impedes an individual's ability to live independently, and (3) Of such a nature that such ability could be improved by more suitable housing conditions.		
25. *PHYSICAL DISABILITY	<input type="checkbox"/> No <input type="checkbox"/> Yes → 26A. IS THIS A DISABLING CONDITION?	<input type="checkbox"/> No <input type="checkbox"/> Yes □ Doesn't Know □ Refused □ Not Collected
26. *DEVELOPMENTAL DISABILITY	<input type="checkbox"/> No <input type="checkbox"/> Yes → 27A. IS THIS A DISABLING CONDITION?	<input type="checkbox"/> No <input type="checkbox"/> Yes □ Doesn't Know □ Refused □ Not Collected
27. *CHRONIC HEALTH CONDITION	<input type="checkbox"/> No <input type="checkbox"/> Yes → 28A. IS THIS A DISABLING CONDITION?	<input type="checkbox"/> No <input type="checkbox"/> Yes □ Doesn't Know □ Refused □ Not Collected
28. *HIV/AIDS	<input type="checkbox"/> No <input type="checkbox"/> Yes → 29A. IS THIS A DISABLING CONDITION?	<input type="checkbox"/> No <input type="checkbox"/> Yes □ Doesn't Know □ Refused □ Not Collected
29. *MENTAL HEALTH PROBLEM	<input type="checkbox"/> No <input type="checkbox"/> Yes → 30A. IS THIS A DISABLING CONDITION?	<input type="checkbox"/> No <input type="checkbox"/> Yes □ Doesn't Know □ Refused □ Not Collected
30. *SUBSTANCE ABUSE PROBLEM	<input type="checkbox"/> No <input type="checkbox"/> Yes, Alcohol → 31A. IS THIS A DISABLING CONDITION? <input type="checkbox"/> Yes, Drugs → □ No <input type="checkbox"/> Yes <input type="checkbox"/> Yes, Both →	□ Doesn't Know □ Refused □ Not Collected

***OTHER PROGRAM ELEMENTS – Clients Over 18 & Heads of Household**

31. *DOMESTIC ABUSE VICTIM/SURVIVOR		
<input type="checkbox"/> No <input type="checkbox"/> Yes → COMPLETE 31A & 31B □ Doesn't Know □ Refused □ Not Collected		
31A. WHEN DID THE EXPERIENCE OCCUR? <input type="checkbox"/> Within the past 3 months <input type="checkbox"/> 4-6 months ago <input type="checkbox"/> 7-12 months ago <input type="checkbox"/> Over 1 year ago		
31B. ARE YOU CURRENTLY FLEEING? <input type="checkbox"/> No <input type="checkbox"/> Yes		
32. *ZIP CODE OF LAST PERMANENT ADDRESS		
_____ OR City: _____ & State: _____		
33. SERVICES SOUGHT		
<input type="checkbox"/> Shelter/Housing	<input type="checkbox"/> Mental Health Care	<input type="checkbox"/> Legal Aid - CRJS/Civil
<input type="checkbox"/> Drug Treatment	<input type="checkbox"/> Medical Care	<input type="checkbox"/> Legal Aid - Immigration
34. ADDITIONAL SERVICES		
<input type="checkbox"/> Client has CDPHP Managed Medicaid <input type="checkbox"/> Client does not have CDPHP Managed Medicaid		

END