2019 CARES REGIONAL HMIS
Transitional Housing – INTAKE

Instructions: Fill out one form per client at project entry, along with the CRHMIS Client Inclusion Disclosure & Release of Information. Any client over 17 years of age is considered an adult. Starred (*) questions require a response.

UNIVERSAL DATA ELEMENTS

Questions below are required for: *All Clients

1. *INTAKE DATE	2. *BED/UNIT	3. PRIMARY WORKER (CASE WORKER)	
____/____/____			
4. *FIRST NAME	5. MIDDLE NAME	6. *LAST NAME & SUFFIX	7. ALIAS

8. *NAME DATA QUALITY
❑ Full Name Reported ❑ Partial Name, Street Name, or Code Name Reported ❑ *Doesn't Know* ❑ *Refused* ❑ *Not Collected*

9. *SOCIAL SECURITY NUMBER
___ ___ ___ – ___ ___ – ___ ___ ___ ___
Enter "9" for any missing numbers in an approx. or partial SSN

10. *SSN DATA QUALITY
❑ Full SSN Reported
❑ Approximate or Partial SSN Reported
❑ *Doesn't Know* ❑ *Refused* ❑ *Not Collected*

11. *GENDER
❑ Female ❑ Trans Female (MTF or Male to Female) ❑ Gender Non-Conforming (Doesn't identify as male, female, or transgendered)
❑ Male ❑ Trans Male (FTM or Female to Male)
❑ *Doesn't Know* ❑ *Refused* ❑ *Not Collected*

12. *BIRTHDATE
____/____/____

13. *BIRTHDATE DATA QUALITY
❑ Full DOB Reported
❑ Approximate or Partial DOB Reported
❑ *Doesn't Know* ❑ *Refused* ❑ *Not Collected*

14. *ETHNICITY
❑ Hispanic/Latino ❑ Non-Hispanic/Non-Latino ❑ *Doesn't Know* ❑ *Refused* ❑ *Not Collected*

15. *RACE (Please check all that apply)
❑ American Indian or Native Alaskan ❑ Asian ❑ White
❑ Black or African American ❑ Native Hawaiian/Other Pacific Islander ❑ *Doesn't Know* ❑ *Refused* ❑ *Not Collected*

16. *VETERAN STATUS
❑ No ❑ Yes ❑ *Doesn't Know* ❑ *Refused* ❑ *Not Collected*

Questions below are required for: *All Adults & Heads of Household

17. *LOCATION PRIOR TO PROJECT ENTRY: Where did the client spend last night? (Select the best match to the client's response – does not need to be exact!)

HOMELESS SITUATIONS
- ❑ **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)
- ❑ Safe Haven
- ❑ **Emergency shelter,** including hotel or motel paid for with emergency shelter voucher
- ❑ **Interim Housing**

INSTITUTIONAL SITUATIONS
- ❑ Foster care home or foster care group home
- ❑ Long-term care facility or nursing home
- ❑ **Hospital** or other residential non-psychiatric medical facility
- ❑ **Psychiatric hospital** or other psychiatric facility
- ❑ **Jail**, prison, or juvenile detention facility
- ❑ **Substance abuse treatment facility** or detox center

TRANSITIONAL & PERMANENT HOUSING SITUATIONS
- ❑ **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)**
- ❑ **Permanent housing (other than RRH)** for formerly homeless persons
- ❑ **Owned by client, no ongoing subsidy**
- ❑ Owned by client, with ongoing subsidy
- ❑ **Hotel or motel** paid for **without emergency shelter voucher**
- ❑ Residential project or halfway house with no homeless criteria
- ❑ **Staying/living in family member's** room, apartment, or house
- ❑ **Staying/living in friend's** room, apartment, or house
- ❑ **Transitional housing** for homeless persons (incl. homeless youth)

POOR DATA/UNKNOWN OPTIONS – 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
❑ 90 days or more, but less than 1 year ❑ 1 month or more, but less than 90 days ❑ 1 year or longer

19. Use the client's response to Question 17 to continue:

If the client came from a HOMELESS SITUATION:
REGARDLESS OF LENGTH OF STAY, COMPLETE SECTION A

If the client came from an INSTITUTIONAL SITUATION:
DID THEY STAY LESS THAN 90 DAYS? ↓

If the client came from a TRANSITIONAL or PERMANENT HOUSING SITUATION:
DID THEY STAY LESS THAN 7 DAYS? ↓

❑ No → SKIP SECTION A
❑ Yes → **IF YES, THE NIGHT BEFORE THAT, WERE THEY ON THE STREETS, IN ES, OR SH?**
❑ No → SKIP SECTION A
❑ Yes → COMPLETE SECTION A

SECTION A – *DETAILS OF CHRONIC HOMELESSNESS*

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

21. *NUMBER OF TIMES IN HOMELESS SITUATIONS IN THE PAST 3 YEARS (include today as 1 time or episode)
❑ 1 ❑ 2 ❑ 3 ❑ 4 or more

22. *TOTAL NUMBER OF MONTHS IN HOMELESS SITUATIONS IN THE PAST 3 YEARS (round up to the full month)
❑ 1 month (this time is the first) ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12 ❑ More than 12

[CONTINUE TO NEXT PAGE]

PROGRAM-SPECIFIC DATA ELEMENTS

Questions below are required for: *All Adults & Heads of Household

23. *INCOME FROM ANY SOURCE

❑ No ❑*Doesn't Know* ❑*Refused* ❑*Not Collected*

❑ Yes → **IF YES, CHECK & PROVIDE MONTHLY AMOUNT FOR ALL SOURCES THAT APPLY BELOW:**

- ❑ Earned Income (i.e., employment pay)...................... $________
- ❑ Unemployment Insurance..$________
- ❑ 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 .... $________
- ❑ Alimony and Other Spousal Support ....$________

24. *NON-CASH BENEFITS FROM ANY SOURCE

❑ No ❑*Doesn't Know* ❑*Refused* ❑*Not Collected*

❑ Yes → **IF YES, CHECK ALL SOURCES THAT APPLY BELOW:**

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

Questions below are required for: *All Clients

25. *COVERED BY HEALTH INSURANCE

❑ No ❑*Doesn't Know* ❑*Refused* ❑*Not Collected*

❑ Yes → **IF YES, CHECK ALL SOURCES THAT APPLY BELOW:**

- ❑ MEDICAID
- ❑ MEDICARE
- ❑ State Children's Health Insurance Program
- ❑ VA Medical Services
- ❑ Employer-Provided Health Insurance
- ❑ Health Insurance through COBRA
- ❑ Private Pay Health Insurance
- ❑ State Health Insurance for Adults
- ❑ Indian Health Services Program

SPECIAL NEEDS – The following information helps 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.

26. *PHYSICAL DISABILITY ❑ No ❑*Doesn't Know* ❑*Refused* ❑*Not Collected*
❑ Yes → **IF YES, IS THIS A DISABLING CONDITION?** ❑ No ❑ Yes

27. *DEVELOPMENTAL DISABILITY ❑ No ❑*Doesn't Know* ❑*Refused* ❑*Not Collected*
❑ Yes → **IF YES, IS THIS A DISABLING CONDITION?** ❑ No ❑ Yes

28. *CHRONIC HEALTH CONDITION ❑ No ❑*Doesn't Know* ❑*Refused* ❑*Not Collected*
❑ Yes → **IF YES, IS THIS A DISABLING CONDITION?** ❑ No ❑ Yes

29. *HIV/AIDS ❑ No ❑*Doesn't Know* ❑*Refused* ❑*Not Collected*
❑ Yes → **IF YES, IS THIS A DISABLING CONDITION?** ❑ No ❑ Yes

30. *MENTAL HEALTH PROBLEM ❑ No ❑*Doesn't Know* ❑*Refused* ❑*Not Collected*
❑ Yes → **IF YES, IS THIS A DISABLING CONDITION?** ❑ No ❑ Yes

31. *SUBSTANCE ABUSE PROBLEM ❑ No ❑ Yes, Alcohol → ❑ Yes, Both → ❑ Yes, Drugs → **IF YES TO ANY, IS THIS A DISABLING CONDITION?** ❑ No ❑ Yes ❑*Doesn't Know* ❑*Refused* ❑*Not Collected*

Questions below are required for: *All Adults & Heads of Household

32. *DOMESTIC ABUSE VICTIM/SURVIVOR

❑ No ❑*Doesn't Know* ❑*Refused* ❑*Not Collected*

❑ Yes → **IF YES, WHEN DID THE EXPERIENCE OCCUR?** ❑ Within the past 3 months ❑ 4-6 months ago ❑ 7-12 months ago ❑ Over 1 year ago

IF YES, ARE YOU CURRENTLY FLEEING? ❑ No ❑ Yes

33. *ZIP CODE OF LAST PERMANENT ADDRESS

____ ____ ____ ____ ____ **OR** City: ____________________ & State:________________________

34. PHONE NUMBER

❑ No

❑ Yes → **IF YES, PHONE #:** (___ ___ ___) - ___ ___ ___ - ___ ___ ___ ___ **OR** ❑ Did not want to provide

35. SERVICES SOUGHT

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

36. ADDITIONAL SERVICES

- ❑ Client has CDPHP Managed Medicaid
- ❑ Client does not have CDPHP Managed Medicaid

*Covid Screening

37. HAVE YOU TESTED POSTIVE FOR COVID-19	**37a.** IF SO WHEN?	
❑ Yes ❑ No	______/_____/________	
37. HAVE YOU RESTESTED AS NEGATIVE SINCE THEN?	**37a.** IF SO WHEN?	
❑Yes ❑ No	______/_____/________	
38. ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?		
❑ New or worsening cough	❑ Fever or chills	❑ Sore throat
❑ New shortness of breath	❑ Difficulty breathing	❑ Fatigue
❑ Muscle or body aches	❑ Loss of taste or smell	❑ Congestion or runny nose
❑ Nausea or vomiting	❑ Diarrhea	
39. HAVE YOU TRAVELED OUTSIDE OF NEW YORK STATE IN THE LAST 14 DAYS?	**39a.** IF YES, WHICH STATE?	
❑ Yes ❑ No		
40. DATE OF RETURN TO NY	CURRENT TRAVEL AND QUARENTINE GUIDANCE	
	https://coronavirus.health.ny.gov/covid-19-travel-advisory	
1. IS THIS PERSON GOING TO BE ISOLATED FOR A TRAVEL RELATED QUARANTINE?	**42.** *IS THIS PERSON GOING TO BE ISOLATED FOR SUSPECTED COVID-19	
❑Yes ❑ No	❑Yes ❑ No ❑ Data Not Collected	

[END OF FORM]