2020 CARES REGIONAL HMIS

# HUD:ESG/STEHP – Emergency Shelter – INTAKE

CARES OF NY, INC
ENDING HOMELESSNESS

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

## *Covid Screening

| **35. HAVE YOU TESTED POSTIVE FOR COVID-19** | **35a. IF SO WHEN?** |
|---|---|
| q. Yes ❑ No | _____/____/_____ |
| **36. HAVE YOU RESTESTED AS GEATIVE SINCE THEN?** | **36a. IF SO WHEN?** |
| ❑Yes ❑ No | _____/____/_____ |

**37. ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?**

| | | |
|---|---|---|
| a. New or worsening cough | ❑ Fever or chills | ❑ Sore throat |
| b. New shortness of breath | ❑ Difficulty breathing | ❑ Fatigue |
| c. Muscle or body aches | ❑ Loss of taste or smell | ❑ Congestion or runny nose |
| d. Nausea or vomiting | ❑ Diarrhea | |

| **38. HAVE YOU TRAVELED OUTSIDE OF NEW YORK STATE IN THE LAST 14 DAYS?** | **38a. IF YES, WHICH STATE?** |
|---|---|
| q. Yes ❑ No | |
| **39. DATE OF RETURN TO NY** | **CURRENT TRAVEL AND QUARENTINE GUIDANCE** |
| | https://coronavirus.health.ny.gov/covid-19-travel-advisory |
| **40. IS THIS PERSON GOING TO BE ISOLATED FOR A TRAVEL RELATED QUARANTINE?** | **41. *IS THIS PERSON GOING TO BE ISOLATED FOR SUSPECTED COVID-19** |
| ❑Yes ❑ No | ❑Yes ❑ No |

## *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** | **7. ALIAS** |
|---|---|
| ❑ Full Name Reported<br>❑ Partial Name, Street Name, or Code Name Reported<br>❑ *Doesn't Know* ❑ *Refused* ❑ *Not Collected* | |

| **8. *SOCIAL SECURITY NUMBER** | **9. *SSN DATA QUALITY** |
|---|---|
| *(Enter "9" for any missing numbers in an approx. or partial SSN)*<br>_____-_____-_____ | ❑ Full SSN Reported<br>❑ Approximate or Partial SSN Reported<br>❑ *Doesn't Know* ❑ *Refused* ❑ *Not Collected* |

**10. *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*

| **11. *BIRTHDATE** | **12. *BIRTHDATE DATA QUALITY** |
|---|---|
| ____/____/_____ | ❑ Full DOB Reported<br>❑ Approximate or Partial DOB Reported<br>❑ *Doesn't Know* ❑ *Refused* ❑ *Not Collected* |

**13. *ETHNICITY**

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

**14. *RACE – 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*

**15. *PHONE NUMBER**: Does the client have a phone number at which they can be reached?

❑ No ❑ Yes → **15A.** PROVIDE # WITH AREA CODE (_____) -_____-_____ OR ❑*Refused to provide phone number*

**16. *VETERAN STATUS**

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

**CONTINUE**

## *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* | *INSTITUTIONAL SITUATIONS* | *TRANSITIONAL / PERMANENT HOUSING 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) | ❑ Foster care home or foster care group home | ❑ **Rental by client, no ongoing subsidy** |
| ❑ Safe Haven | ❑ Long-term care facility or nursing home | ❑ Rental by client, with GPD TIP subsidy |
| ❑ **Emergency shelter**, including hotel or motel paid for with emergency shelter voucher | ❑ **Hospital** or other residential non-psychiatric medical facility | ❑ Rental by client, with VASH subsidy |
| | ❑ **Psychiatric hospital** or other psychiatric facility | ❑ **Rental by client,** with **other housing subsidy (including RRH)** |
| | ❑ **Jail**, prison, or juvenile detention facility | ❑ **Permanent housing (other than RRH)** for formerly homeless persons |
| | ❑ **Substance abuse treatment facility** or detox center | ❑ **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/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

Use the client's location category from question 18 to continue:

| *HOMELESS SITUATIONS* | *INSTITUTIONAL SITUATIONS* | *TRANSITIONAL / PERMANENT HOUSING SITUATIONS* |
|---|---|---|
| → **COMPLETE SECTION B** | **18A.** DID THE CLIENT STAY THERE LESS THAN 90 DAYS?<br>❑ No → SKIP SECTION B<br>❑ Yes → **18B.** THE NIGHT BEFORE THAT, WERE THEY ON THE STREETS, IN ES, OR SH?<br>❑ No → SKIP SECTION B<br>❑ Yes → **COMPLETE SECTION B** | **18A**. DID THE CLIENT STAY THERE LESS THAN 7 DAYS?<br>❑ No → SKIP SECTION B<br>❑ Yes → **18B.** THE NIGHT BEFORE THAT, WERE THEY ON THE STREETS, IN ES, OR SH?<br>❑ No → SKIP SECTION B<br>❑ Yes → **COMPLETE SECTION B** |

**SECTION B – DETAILS OF CHRONIC HOMELESSNESS**

**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

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

**22. *INCOME FROM ANY SOURCE**

❑ No ❑ Yes → **22A.** CHECK & PROVIDE MONTHLY AMOUNT FOR ALL SOURCES THAT APPLY BELOW ❑*Doesn't Know* ❑*Refused* ❑*Not Collected*

| | |
|---|---|
| ❑ 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 ..... $_____ |

**23. *NON-CASH BENEFITS FROM ANY SOURCE**

❑ No ❑ Yes → **23A.** CHECK ALL SOURCES THAT APPLY BELOW ❑*Doesn't Know* ❑*Refused* ❑*Not Collected*

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

**CONTINUE**

## *HEALTH – All Clients

| **24. *COVERED BY HEALTH INSURANCE** | | | |
|---|---|---|---|
| ❑ No ❑ Yes → **24A.** CHECK ALL SOURCES THAT APPLY BELOW | | | ❑*Doesn't Know* ❑*Refused* ❑*Not Collected* |
| ❑ 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 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** | ❑ No ❑ Yes → **25A.** IS THIS A DISABLING CONDITION? ❑ No ❑ Yes | ❑ *Doesn't Know* ❑*Refused* ❑*Not Collected* |
| **26. *DEVELOPMENTAL DISABILITY** | ❑ No ❑ Yes | ❑ *Doesn't Know* ❑*Refused* ❑*Not Collected* |
| **27. *CHRONIC HEALTH CONDITION** | ❑ No ❑ Yes → **27A.** IS THIS A DISABLING CONDITION? ❑ No ❑ Yes | ❑ *Doesn't Know* ❑*Refused* ❑*Not Collected* |
| **28. *HIV/AIDS** | ❑ No ❑ Yes | ❑ *Doesn't Know* ❑*Refused* ❑*Not Collected* |
| **29. *MENTAL HEALTH PROBLEM** | ❑ No ❑ Yes → **29A.** IS THIS A DISABLING CONDITION? ❑ No ❑ Yes | ❑ *Doesn't Know* ❑*Refused* ❑*Not Collected* |
| **30. *SUBSTANCE ABUSE PROBLEM** | ❑ No ❑ Yes, Alcohol ❑ Yes, Drugs ❑ Yes, Both → **30A.** IS THIS A DISABLING CONDITION? ❑ No ❑ Yes | ❑ *Doesn't Know* ❑*Refused* ❑*Not Collected* |

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

| **31. *DOMESTIC ABUSE VICTIM/SURVIVOR** | | | | |
|---|---|---|---|---|
| ❑ No ❑ Yes → COMPLETE 31A & 31B | | | | ❑*Doesn't Know* ❑*Refused* ❑*Not Collected* |
| **31A.** WHEN DID THE EXPERIENCE OCCUR? ❑ Within the past 3 months | ❑ 4-6 months ago | ❑ 7-12 months ago | ❑ Over 1 year ago | |
| **31B.** ARE YOU CURRENTLY FLEEING? ❑ No ❑ Yes | | | | |

**32. *ZIP CODE OF LAST PERMANENT ADDRESS**

_____ **OR** City:_____ & State:_____

**33. SERVICES SOUGHT**

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

**34. ADDITIONAL SERVICES**

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

**END**