2020 CARES COLLABORATIVE HMIS

HUD:ESG/STEHP – Emergency Shelter – INTAKE

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

*Covid Screening

35. Have you been in close contact over the last 14 days with anyone who has tested positive for COVID-19?	**36.** HAVE YOU TESTED POSTIVE FOR COVID-19
❑Yes ❑ No	❑Yes ❑ No
36a. IF SO WHEN?	**37.** HAVE YOU RESTESTED AS GEATIVE SINCE THEN?
______/_____/________	❑Yes ❑ No
37a. IF SO WHEN?	
______/_____/________	
38. ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?	
❑ New or worsening cough ❑ New shortness of breath ❑ Muscle or body aches ❑ Nausea or vomiting ❑ Fever or chills ❑ Difficulty breathing ❑ Loss of taste or smell ❑ Diarrhea	❑ Sore throat ❑ Fatigue ❑ Congestion or runny nose ❑ Headache
39. HAVE YOU TRAVELED OUTSIDE OF NEW YORK STATE IN THE LAST 14 DAYS?	**39a.** IF YES, WHICH STATE?
❑Yes ❑ No	
CURRENT TRAVEL AND QUARENTINE GUIDANCE	
https://coronavirus.health.ny.gov/covid-19-travel-advisory	
40. HAVE YOU TRAVELED WTHIN NYS (COUNTY TO COUNTY) IN THE LAST 14 DAYS?	**40a.** IF YES WHICH COUNTY
❑Yes ❑ No	
PLEASE CLICK LINK BELOE TO SEE WHAT COUNTIES ARE CURRENTLY A HOTSPOT	
https://covid19tracker.health.ny.gov/	
41. 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

*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 ❑ Partial Name, Street Name, or Code Name Reported	*❑ 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) _________-_______- ____________	❑ Full SSN Reported ❑ Approximate or Partial SSN Reported	*❑ Doesn't Know ❑ Refused ❑ Not Collected*
10. *GENDER		
❑ Female ❑ Trans Female (MTF or Male to Female) ❑ Male ❑ Trans Male (FTM or Female to Male)	❑ Gender Non-Conforming (Doesn't identify as male, female, or transgendered)	*❑ Doesn't Know ❑ Refused ❑ Not Collected*
11. *BIRTHDATE	**12.** *BIRTHDATE DATA QUALITY	
____/____/_____	❑ Full DOB Reported ❑ Approximate or Partial DOB Reported	*❑ 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 ❑ Black or African American	❑ Asian ❑ Native Hawaiian/Other Pacific Islander	❑ White *❑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
- ❑ **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

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/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

→ **COMPLETE SECTION B**

INSTITUTIONAL SITUATIONS

18A. DID THE CLIENT STAY THERE LESS THAN 90 DAYS?
- ❑ No → SKIP SECTION B
- ❑ Yes → **18B.** THE NIGHT BEFORE THAT, WERE THEY ON THE STREETS, IN ES, OR SH?
  - ❑ No → SKIP SECTION B
  - ❑ Yes → **COMPLETE SECTION B**

TRANSITIONAL / PERMANENT HOUSING SITUATIONS

18A. DID THE CLIENT STAY THERE LESS THAN 7 DAYS?
- ❑ No → SKIP SECTION B
- ❑ Yes → **18B.** THE NIGHT BEFORE THAT, WERE THEY ON THE STREETS, IN ES, OR SH?
  - ❑ No → SKIP SECTION B
  - ❑ 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) .... $_______
- ❑ Supplemental Security Income (SSI) .... $_______
- ❑ VA Service-Connected Disability Compensation................... $_______
- ❑ Private Disability Insurance .... $_______
- ❑ Temporary Assistance for Needy Families (TANF) .... $_______
- ❑ Retirement Income from Social Security............................... $_______
- ❑ Child Support... $_______
- ❑ Unemployment Insurance..$_______
- ❑ Social Security Disability Insurance (SSDI).........................$_______
- ❑ VA Non-Service Connected Disability Pension ....$_______
- ❑ Worker's Compensation.. $_______
- ❑ General Assistance (GA)..$_______
- ❑ Pension or Retirement Income from Former Job ....$_______
- ❑ Alimony and Other Spousal Support..................................$_______

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.

Question	Response	Disabling condition	
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