|  |  |
| --- | --- |
| Logo  Description automatically generated | **FY24 CARES COLLABORATIVE HMIS EMERGENCY SHELTER** **INTAKE** (Universal & Program Specific Data Elements) |

*Instructions: Fill out one form per client/household member at project entry, along with the CCHMIS Client Inclusion Disclosure and Release of Information. Starred (\*) questions require a response.*

All of the data entered on this form must be information that has been asked of and provided by the client. It is required that you ask each client each question that is on the form, however a client can decline to provide an answer or may not know the answer. In this case there are specific response options that must be selected to indicate so. There is the response option of data not collected, however this should never be selected as again you are required to ask clients each question.

**UNIVERSAL DATA ELEMENTS**

Questions below are required for: All Clients & Household Members

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| \*Project Entry Date | | \*First Name | | | | | \*Last Name | |
| Click or tap to enter a date. | | Click or tap here to enter text. | | | | | Click or tap here to enter text. | |
| \*Name Data Quality | | | | | | | | |
| Choose an item. | | | | | | | | |
| \*Social Security Number – **If Unknown or Client Prefers Not to Answer enter 999-99-9999** | | | \*Social Security Number Data Quality | | | | | |
| Click or tap here to enter text. | | | Choose an item. | | | | | |
| \*Which gender or genders do you identify with? (Select all that apply) | | | | | | | | |
| Woman (Girl if child)  Transgender  Different IdentityClick or tap here to enter text. | | | | Man (Boy if child)  Non-binary | | Culturally Specific Identity (e.g., Two-Spirit)  Questioning | | *Doesn’t Know*  *Prefers Not to Answer*  *Not Collected* |
| \*What is your Date of Birth? | \*Birthdate Data Quality | | | | | | | |
| Click or tap to enter a date. | Choose an item. | | | | | | | |
| \*Which races and ethnicities do you identify as? (Select all that apply) | | | | | | | | |
| American Indian, Native Alaskan, or Indigenous Black, African American, African  Middle Eastern or North African  White | | | | | Asian or Asian American  Hispanic/Latina/e/o  Native Hawaiian or Pacific Islander | | | *Doesn’t Know*  *Prefers Not to Answer*  *Not Collected* |
| Would you like to add any additional information regarding your race/ethnic identity? | | | | | | | | |
| Additional Information Click or tap here to enter text. | | | | | | | | |
| \*Have you ever served in the United States Military? | | | | | | | | |
| Choose an item. | | | | | | | | |

**(Continue on Next Page)**

**UNIVERSAL DATA ELEMENTS Continued…**

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

|  |  |
| --- | --- |
| **PRIOR LIVING SITUATION** | |
| \*Where did you sleep last night? **(Select the best match to the person’s response – does not need to be exact!)** | |
| HOMELESS SITUATIONS  Choose an item. | INSTITUTIONAL SITUATIONS  Choose an item. |
| TEMPORARY HOUSING SITUATIONS  Choose an item. | PERMANENT HOUSING SITUATIONS  Choose an item. |
| **\*IF RENTAL OR OWNED WITH ONGOING SUBSIDY, What type of subsidy are you receiving?** | |
| Choose an item. | |
| Poor Data/Unknown Options – ***USE ONLY IF NECESSARY***: Choose an item. | |
| \* How long have you been staying where you spent last night? | |
| Choose an item. | |
| \*About what date did you become homeless just before coming here? | |
| \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ | |
| \*How many times have you experienced homelessness in the last 3 years? | |
| Choose an item. | |
| \*In the last 3 years about how many total months have you experienced homelessness? (round up to the full month) | |
| Choose an item. | |

**PROJECT SPECIFIC DATA ELEMENTS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **\***Do you have any type of income? – **If Yes,** indicate and provide the monthly amount for all sources that apply below | | | | | |
| No Yes  Earned Income (i.e., employment pay)…………………………………………………………………………… $ Click or tap here to enter text.  Supplemental Security Income (SSI)…………………………………………………………………………...…. $ Click or tap here to enter text.  VA Service-Connected Disability Compensation………………………………………………………………. $ Click or tap here to enter text.  Private Disability Insurance……………………………………………………………………………………………. $ Click or tap here to enter text.  Temporary Assistance for Needy Families (TANF)…………………………………………………………… $ Click or tap here to enter text.  Retirement Income from Social Security…………………………………………………………………………. $ Click or tap here to enter text.  Child Support………………………………………………………………………………………………………………… $ Click or tap here to enter text.  Unemployment Insurance………………………………………………………………………………………………. $ Click or tap here to enter text.  Social Security Disability Insurance (SSDI)………………………………………………………………………. $ Click or tap here to enter text.  VA Non-Service-Connected Disability Pension…………………………………………………………………. $ Click or tap here to enter text.  Worker’s Compensation…………………………………………………………………………………...……………. $ Click or tap here to enter text.  General Assistance…………………………………………………………………………………………………………. $ Click or tap here to enter text.  Pension or Retirement Income from a Former Job…………………………………………………………… $ Click or tap here to enter text.  Alimony or Other Spousal Support…………………………………………………………………………………. $ Click or tap here to enter text. | | | | | |
| *Doesn’t Know* *Prefers Not to Answer* *Not Collected* | | | | | |
| \*Are you receiving any type of non-cash benefits? – **If Yes**, indicate all sources that apply below | | | | | |
| No Yes  SNAP (Food Benefits)  TANF Child Care Services | | | | Special supplemental Nutrition Program for Women, Infants and Children (WIC)  TANF Transportation Services  Other TANF-Funded Services | |
| *Doesn’t Know* *Prefers Not to Answer* *Not Collected* | | | | | |
| \*Are you covered by health insurance? – **If Yes**, indicate all sources below | | | | | |
| No Yes  MEDICAID  VA Medical Services  Private Pay Health Insurance | | MEDICARE  Employer-Provided Health Insurance  State Health Insurance for Adults | | | State Children’s Health Insurance Program  Health Insurance Through COBRA  Indian Health Services Program |
| *Doesn’t Know* *Prefers Not to Answer* *Not Collected* | | | | | |
| SPECIAL CONDITONS – *The following information helps determine if there are additional housing services or benefits available for this person* | | | Select **YES** to any condition if (1) It is expected to be long-continuing or forever; (2) Substantially impedes their ability to live independently; AND (3) Could be improved by having access to more suitable housing conditions. | | |
| \*Do you have a Physical Disability? | No  Yes g **If Yes**, is this a disabling condition? No Yes  *Doesn’t Know* *Prefers Not to Answer* *Not Collected* | | | | |
| \* Do you have a Developmental Disability? | No  Yes  *Doesn’t Know* *Prefers Not to Answer* *Not Collected* | | | | |
| \* Do you have a Chronic Health Condition? | No  Yes g **If Yes**, is this a disabling condition? No Yes  *Doesn’t Know* *Prefers Not to Answer* *Not Collected* | | | | |
| \*Have you been diagnosed with HIV/AIDS? | No  Yes  *Doesn’t Know* *Prefers Not to Answer* *Not Collected* | | | | |
| \* Do you have a Mental Health Disorder? | No  Yes g **If Yes**, is this a disabling condition? No Yes  *Doesn’t Know* *Prefers Not to Answer* *Not Collected* | | | | |
| \* Do you currently or ever have a Substance Use Disorder? | No  Yes, Alcohol use disorder g If **Yes**, is this a disabling condition? No Yes  Yes, Both Alcohol and Drug use disorder g **If Yes**, is this a disabling condition? No Yes  Yes, Drug us disorder g **If Yes**, is this a disabling condition? No Yes  *Doesn’t Know* *Prefers Not to Answer* *Not Collected* | | | | |

Questions below are required for: All Adults &/or Heads of Households

|  |  |  |
| --- | --- | --- |
| \*Are you a survivor of Domestic Violence? – If Yes, please answer the additional questions **Head of Household & Adults** | | |
| No 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  Are you currently fleeing from a domestic violence situation? No Yes  *Doesn’t Know**Prefers Not to Answer*  *Not Collected* | | |
| \*Do you need any help with language translation? – **If Yes**, please select the language for translation: **Head of Household Only** | | |
| Choose an item. | Language:  Choose an item. | Different Preferred Language  Please Specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \*Zip Code of Last Permanent Address | | |
| Click or tap here to enter text. *or* City Click or tap here to enter text. *or* State Click or tap here to enter text. | | |