

HMIS Standard Intake Form for TBRA projects

Effective 07/01/2020

Intake Date

		/			/		
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Entry Date

		/			/		
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ServicePoint (HoH) ID:

--	--	--	--	--	--	--	--

Project Name

--

HoH First Name

--

Middle

--

Last

--

Suffix

--

Alias

--

Full Name Reported

Partial, Street or Code Name

Client doesn't know

Client Refused

Social Security Number:

--	--	--	--	--	--	--	--	--	--

Full SSN reported

Approx or Partial SSN

Client doesn't know

Client refused

Date of Birth:

		/			/		
--	--	---	--	--	---	--	--

Full DOB reported

Approx or Partial DOB

Client doesn't know

Client refused

Race (Select all that apply)

American Indian or Alaska Native

Black or African American

Native Hawaiian or Other Pacific Islander

Client doesn't know

Asian

Client refused

White

Gender

Female

Client doesn't know

Male

Client refused

Trans Female (MTF or male to female)

Trans Male (FTM or female to male)

Non-Conforming (not exclusively male or female)

Ethnicity

Non-Hispanic/Non-Latino

Client doesn't know

Hispanic/Latino

Client refused

Veteran Status

No

Yes

Relationship to Head of Household (Must be an adult)

Self (Head of Household)

HoH's child

HoH's spouse or partner

HoH's other relation member

Other: non-relation member

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Health Insurance	
<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Yes (identify source below)	<input type="checkbox"/> Client
Source	
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare
<input type="checkbox"/> State Children's Health Insurance (KCHIP)	<input type="checkbox"/> VA Medical Services
<input type="checkbox"/> Employer-Provided Health Insurance	<input type="checkbox"/> Health Insurance obtained through COBRA
<input type="checkbox"/> Private Pay Health Insurance	<input type="checkbox"/> State Health Insurance for Adults
<input type="checkbox"/> Indian Health Services Program	<input type="checkbox"/> Other: _____

Disability						
Do you have a physical, mental or emotional impairment, a post-traumatic stress disorder, or brain injury; a development disability, HIV/AIDS, or a diagnosable substance abuse problem?						
<input type="checkbox"/> No	<input type="checkbox"/> Yes (indicate type(s) below)		<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused		
	Physical <input type="checkbox"/>	Mental Health <input type="checkbox"/>	Chronic Health Condition <input type="checkbox"/>	<input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs <input type="checkbox"/> Both	Developmental <input type="checkbox"/>	HIV/AIDS <input type="checkbox"/>
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

****Only answer the following questions for Adults and HoH. ****

Income	
<input type="checkbox"/> No/None at all	<input type="checkbox"/> Yes (identify source and amounts)
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
Source	Amount:
<input type="checkbox"/> Earned income (i.e., employment income)	\$ _____ . 00
<input type="checkbox"/> Unemployment Insurance	\$ _____ . 00
<input type="checkbox"/> Supplemental Security Income (SSI)	\$ _____ . 00
<input type="checkbox"/> Social Security Disability Income (SSDI)	\$ _____ . 00
<input type="checkbox"/> Retirement Income from Social Security	\$ _____ . 00
<input type="checkbox"/> VA Service-Connected Disability Compensation	\$ _____ . 00
<input type="checkbox"/> VA Non-Service-Connected Disability Pension	\$ _____ . 00
<input type="checkbox"/> Worker's Compensation	\$ _____ . 00
<input type="checkbox"/> Temporary Assistance for Needy Families (TANF)	\$ _____ . 00
<input type="checkbox"/> General Assistance (GA)	\$ _____ . 00
<input type="checkbox"/> Private disability Insurance	\$ _____ . 00
<input type="checkbox"/> Pension or retirement income from a former job	\$ _____ . 00
<input type="checkbox"/> Child Support	\$ _____ . 00
<input type="checkbox"/> Alimony or other spousal support	\$ _____ . 00
<input type="checkbox"/> Other source: _____	\$ _____ . 00
Total Monthly Income:	\$ _____

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Non-Cash Benefits	
<input type="checkbox"/> No/None at all	<input type="checkbox"/> Yes (Identify source below)
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
Source	
<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) <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 <input type="checkbox"/> Other: _____	

Client's Current Living Situation – current to project entry			
(Select one Living Situation and answer the corresponding questions in the order in which they appear)			
Start Date	End Date	Information Date	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
(Select one Living Situation and answer the corresponding questions in the order in which they appear)			
Homeless Situation	Institutional Situation	Transitional/Permanent Housing Situation	Other
<input type="checkbox"/> Place not meant for habitation (e.g. a vehicle, abandoned building, bus/train/subway station, airport, anywhere outside). <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher <input type="checkbox"/> Safe Haven	<input type="checkbox"/> Foster care home or foster group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail, prison or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center	<input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Host Home (non-crisis) Staying or living in a friend's room, apartment or house <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> Rental by client, with GPD TIP housing subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons <input type="checkbox"/> Rental by client, with RRH or equivalent subsidy <input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based) <input type="checkbox"/> Rental by client in a public housing unit <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client with other ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy	<input type="checkbox"/> Other: _____ <input type="checkbox"/> Worker unable to determine <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
Is client going to have to leave their current living situation within 14 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, answer the following questions.		
Has a subsequent residence been identified? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does individual or family have resources or support networks to obtain other permanent housing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has the client had a lease or ownership interest in a permanent housing unit in the last 60 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has the client moved 2 or more times in the past 60 days? <input type="checkbox"/> Yes <input type="checkbox"/> No

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Client's Prior Living Situation - Prior to Project Entry			
(Select one Living Situation and answer the corresponding questions in the order in which they appear)			
Literally Homeless Situation	Institutional Situation	Transitional/Permanent Housing Situation	Other
<input type="checkbox"/> Place not meant for habitation (e.g. a vehicle, abandoned building, bus/train/subway station, airport, anywhere outside). <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher <input type="checkbox"/> Safe Haven	<input type="checkbox"/> Foster care home or foster group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail, prison or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center	<input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Host Home (non-crisis) Staying or living in a friend's room, apartment or house <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> Rental by client, with GPD TIP housing subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons <input type="checkbox"/> Rental by client, with RRH or equivalent subsidy <input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based) <input type="checkbox"/> Rental by client in a public housing unit <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client with other ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
Length of Stay in Prior Living Situation (i.e. the literally homeless situation identified above)? <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more but less than one month <input type="checkbox"/> One month or more but less than 90 days <input type="checkbox"/> 90 days or more but less than one year <input type="checkbox"/> One year or longer	Length of Stay in Prior Living Situation (i.e. the institutional situation identified above)? <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more but less than one month <input type="checkbox"/> One month or more but less than 90 days <input type="checkbox"/> 90 days or more but less than one year <input type="checkbox"/> One year or longer Did you stay in the institutional situation less than 90 days? <input type="checkbox"/> Yes (If YES – Complete SECTION III) <input type="checkbox"/> No (If NO – End Homeless History Interview)	Length of Stay in Prior Living Situation (i.e. the housing situation identified above) <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more but less than one month <input type="checkbox"/> One month or more but less than 90 days <input type="checkbox"/> 90 days or more but less than one year <input type="checkbox"/> One year or longer Did you stay in the housing situation less than 7 nights? <input type="checkbox"/> Yes (If YES – Complete SECTION III) <input type="checkbox"/> No (If NO – End Homeless History Interview)	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
<input type="checkbox"/> N/A (Complete SECTION IV Below)	On the night before entering the institutional situation did you stay on the streets, in emergency shelter or a safe haven? <input type="checkbox"/> Yes (If YES – Complete SECTION IV) <input type="checkbox"/> No (If NO – End Homeless History Interview)	On the night before entering the housing situation did you stay on the streets, in emergency shelter or a safe haven? <input type="checkbox"/> Yes (If YES – Complete SECTION IV) <input type="checkbox"/> No (If NO – End Homeless History Interview)	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused

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On the night <u>before your previous stay</u> , was that on the streets, in an Emergency Shelter, or Safe Haven? <input type="checkbox"/> No <input type="checkbox"/> Yes	Approximate start of homelessness: <table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>										
Total <u>number of times homeless</u> on the street, in ES, or SH in the past three years <input type="checkbox"/> One time <input type="checkbox"/> Two times <input type="checkbox"/> Three times <input type="checkbox"/> Four times <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	Total number of <u>months</u> homeless on the street, in emergency shelter, or SH in the past three years _____										

Domestic Violence	
Are you, or have you been a survivor of domestic or intimate partner violence? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	
If YES, how long ago did you have this experience? <input type="checkbox"/> Within the past 3 months <input type="checkbox"/> 1 year ago or more <input type="checkbox"/> 3 to 6 months ago <input type="checkbox"/> 6 months to 1 year ago <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	
If Yes, are you currently fleeing? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	

Foster Care	Zip Code of Last Permanent Address						
<input type="checkbox"/> Yes <input type="checkbox"/> No	<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>						

Standard Intake

Staff Completing (Printed Name): _____	Date: _____
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