

HMIS Intake Form for Emergency Shelter projects

Effective 10/01/2025

| Intake Date | Entry Date | ServicePoint (HoH) ID: |
|---|--|------------------------|
| <input data-bbox="207 302 306 306" type="text"/> <input data-bbox="306 302 408 306" type="text"/> / <input data-bbox="408 302 507 306" type="text"/> <input data-bbox="507 302 603 306" type="text"/> | <input data-bbox="616 302 716 306" type="text"/> <input data-bbox="716 302 816 306" type="text"/> / <input data-bbox="816 302 915 306" type="text"/> <input data-bbox="915 302 1010 306" type="text"/> | |

Project Name

| | | |
|--|--------|---|
| HoH Name First | Middle | Last |
| | | |
| Suffix | | Alias |
| | | |
| Name Data Quality | | |
| <input type="checkbox"/> Full Name Reported <input type="checkbox"/> Client doesn't know | | <input type="checkbox"/> Partial, Street or Code Name <input type="checkbox"/> Client prefers not to answer |
| Social Security Number | | Date of Birth |
| <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> |
| <input type="checkbox"/> Full SSN Reported (HUD) <input type="checkbox"/> Approx or partial SSN reported (HUD) <input type="checkbox"/> Client doesn't know (HUD) <input type="checkbox"/> Client prefers not to answer (HUD) <input type="checkbox"/> Data Not collected (HUD) | | <input type="checkbox"/> Full DOB Reported (HUD) <input type="checkbox"/> Approx or partial SSN reported (HUD) <input type="checkbox"/> Client doesn't know (HUD) <input type="checkbox"/> Client prefers not to answer (HUD) <input type="checkbox"/> Data Not collected (HUD) |
| Veteran Status | | Relationship to HoH |
| <input type="checkbox"/> No <input type="checkbox"/> Yes | | <input type="checkbox"/> Self (Head of Household) <input type="checkbox"/> HoH's child <input type="checkbox"/> HoH's spouse or partner <input type="checkbox"/> HoH's other <input type="checkbox"/> Other: non-relation relation member member |
| Sex | | |
| <input type="checkbox"/> Female <input type="checkbox"/> Male | | <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected |
| Race and Ethnicity (Select all that apply) | | |
| <input type="checkbox"/> American Indian, Alaska Native, or Indigenous <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black, African American, or African <input type="checkbox"/> Hispanic/Latina/o <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Additional Race and Ethnicity detail: _____ | | <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer |

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| Gender (Select all that apply) | |
|--|---|
| <input type="checkbox"/> Woman (Girl, if child) | <input type="checkbox"/> Questioning |
| <input type="checkbox"/> Man (Boy, if child) | <input type="checkbox"/> Different Identity |
| <input type="checkbox"/> Culturally Specific Identity (e.g., Two-Spirit) | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Transgender | <input type="checkbox"/> Client prefers not to answer |
| <input type="checkbox"/> Non-Binary | |
| <input type="checkbox"/> If Different Identity, Please Specify: _____ | |

| Health Insurance | | | | | | | | | | | | | | | | | |
|---|--|--|---|---|--|--|--|--|--|-----------------------------------|---|-----------------------------------|--|----------------------------------|---|--------------------------------|--|
| <input type="checkbox"/> No | <input type="checkbox"/> Client doesn't know | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Yes (identify source below) | <input type="checkbox"/> Client prefers not to answer | | | | | | | | | | | | | | | | |
| Source | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Medicare | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> State Children's Health Insurance (KCHIP) | <input type="checkbox"/> Veteran's Health Administration (VHA) | | | | | | | | | | | | | | | | |
| <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: _____ | | | | | | | | | | | | | | | | |
| BoS Pre-Housing Survey: Medical Insurance | | | | | | | | | | | | | | | | | |
| Coverage Start Date: <table border="1"><tr><td> </td><td> </td><td> </td><td>/</td><td> </td><td> </td><td> </td><td> </td></tr></table> | | | | / | | | | | Which forms of health insurance do you have? (select multiple options if it applies): <table border="1"><tr><td><input type="checkbox"/> Medicaid</td><td><input type="checkbox"/> Commercial Insurance</td></tr><tr><td><input type="checkbox"/> Medicare</td><td><input type="checkbox"/> I don't have insurance, but want it</td></tr><tr><td><input type="checkbox"/> Tricare</td><td><input type="checkbox"/> I don't know/need to figure it out</td></tr><tr><td><input type="checkbox"/> Other</td><td></td></tr></table> | <input type="checkbox"/> Medicaid | <input type="checkbox"/> Commercial Insurance | <input type="checkbox"/> Medicare | <input type="checkbox"/> I don't have insurance, but want it | <input type="checkbox"/> Tricare | <input type="checkbox"/> I don't know/need to figure it out | <input type="checkbox"/> Other | |
| | | | / | | | | | | | | | | | | | | |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Commercial Insurance | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> I don't have insurance, but want it | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Tricare | <input type="checkbox"/> I don't know/need to figure it out | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Other | | | | | | | | | | | | | | | | | |
| Enter the name of the Health Insurance carrier: <table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table> | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| Coverage Effective Date: <table border="1"><tr><td> </td><td> </td><td> </td><td>/</td><td> </td><td> </td><td> </td><td> </td></tr></table> | | | | / | | | | | Enter Medicaid/Member ID: <table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table> | | | | | | | | |
| | | | / | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| Enter Member Group No: <table border="1"><tr><td> </td><td> </td><td> </td><td>/</td><td> </td><td> </td><td> </td><td> </td></tr></table> | | | | / | | | | | Coverage End Date: <table border="1"><tr><td> </td><td> </td><td> </td><td>/</td><td> </td><td> </td><td> </td><td> </td></tr></table> | | | | / | | | | |
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| 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 prefers not to answer | | | | |
| | 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"/> |

| 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) | | | | |
| Homeless Situations | Institutional Situations | Temporary Housing Situations | Permanent Housing Situation | Other |
| <input type="checkbox"/> Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher, Host Home shelter <input type="checkbox"/> Safe Haven | <input type="checkbox"/> Foster care home or foster care 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"/> Transitional housing for homeless persons (including homeless youth) <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"/> Host Home (non-crisis) <input type="checkbox"/> 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, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with ongoing housing subsidy <ul style="list-style-type: none"> <input type="radio"/> GPD TIP housing subsidy <input type="radio"/> VASH housing subsidy <input type="radio"/> RRH or equivalent subsidy <input type="radio"/> HCV voucher (tenant or project based) (not dedicated) <input type="radio"/> Public housing unit <input type="radio"/> Rental by client, with other ongoing housing subsidy <input type="radio"/> Emergency Housing Voucher <input type="radio"/> Family Unification Program Voucher (FUP) <input type="radio"/> Foster Youth to Independence Initiative (FYI) <input type="radio"/> Permanent Supportive Housing <input type="radio"/> Other permanent housing dedicated for formerly homeless persons <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 prefers not to answer |
| Length of Stay in Prior Living Situation (i.e. the literally homeless situation identified above)? | Length of Stay in Prior Living Situation (i.e. the institutional situation identified above)? | Length of Stay in Prior Living Situation (i.e. the housing situation identified above)? | 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 night or less <input type="checkbox"/> Two to six nights | <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 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"/> Client doesn't know |

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| | |
|---|---|
| Are you, or have you been a survivor of domestic or intimate partner violence? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer |
| If YES, how long ago did you have this experience? | <input type="checkbox"/> Within the past three months <input type="checkbox"/> Three to six months ago <input type="checkbox"/> From six to twelve months ago <input type="checkbox"/> More than a year ago <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer |
| If Yes, are you currently fleeing? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer |

****IF CLIENT IS A MINOR WHO IS NOT HEAD OF HOUSEHOLD STOP DATA ENTRY HERE****

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| 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 prefers not to answer |
| 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: \$ _____ | |

| 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 prefers not to answer |
| 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: _____ | |

| | |
|--|--|
| In the last 2 years, in what Kentucky county did you become homeless? (If Out of State please indicate): | |
| If you have lived in multiple Kentucky counties in the last 2 years, please specify additional county: | |
| If you have lived in another part of the US in the last 2 years, please specify state: | |

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| | | | | |
|---|--|-----------------------------|--|---|
| If other location in the last 2 years, please specify: | | | | |
| In what Kentucky county are you currently staying?: | | | | |
| Did you have housing when you came to this county/community?: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Client prefers not to answer |
| What is the primary reason you came to this county/community?: | <input type="checkbox"/> Access to service and resources <input type="checkbox"/> Fleeing an abusive situation <input type="checkbox"/> Job Opportunities <input type="checkbox"/> Other <input type="checkbox"/> Client prefers not to answer | | | |
| What are your top 3 reasons you are struggling to find stable, safe and appropriate housing? (number 1,2,3) | <input type="checkbox"/> Affordability <input type="checkbox"/> Don't know where to look <input type="checkbox"/> Household instability <input type="checkbox"/> Size of household <input type="checkbox"/> Poor credit <input type="checkbox"/> Past evictions <input type="checkbox"/> Registered sex offender <input type="checkbox"/> New to the community <input type="checkbox"/> Startup costs/deposits <input type="checkbox"/> Criminal Background <input type="checkbox"/> Owing money to previous landlord <input type="checkbox"/> Owing money to Section 8/government housing <input type="checkbox"/> Availability of rental units <input type="checkbox"/> Other Reasons <input type="checkbox"/> N/A | | | |
| If you are struggling for another reason, please specify: | | | | |
| If client is a Head of Household, have they been evicted? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A | |
| Pick top reason client was evicted? | <input type="checkbox"/> Change in property ownership <input type="checkbox"/> Criminal Activity <input type="checkbox"/> Lease Violation(s) <input type="checkbox"/> Non-Payment of Rent <input type="checkbox"/> Rental property foreclosed | | | |
| If the client is a Veteran, do they have a copy of their DD-214 Form? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A | |
| Client ever in the foster care system? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |

Client Contact Information

| | | |
|--------------------------|--|--|
| Client Phone Number | | |
| Alt. Client Phone Number | | |

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| | | | |
|--|--|--|--|
| Email address/other electronic communication (e.g. social media) | | | |
| On a regular day, where is it easiest to find you and what time of day is easiest to do so? (collect multiple locations) | | | |
| Translation Assistance Needed | | | |
| <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Yes (identify preferred language(s)) <input type="checkbox"/> Client prefers not to answer | | |
| Preferred Language(s) | <input type="checkbox"/> Amharic <input type="checkbox"/> Arabic <input type="checkbox"/> Bosnian <input type="checkbox"/> Burmese <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Croatian <input type="checkbox"/> Dari <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Gujarati <input type="checkbox"/> Haitian Creole <input type="checkbox"/> Hawaiian <input type="checkbox"/> Hindi <input type="checkbox"/> Ilocano <input type="checkbox"/> Japanese <input type="checkbox"/> Karen <input type="checkbox"/> Kinyarwand <input type="checkbox"/> Korean <input type="checkbox"/> Lingala <input type="checkbox"/> Data Not Collected | | |
| <input type="checkbox"/> Luganda <input type="checkbox"/> Mandarin <input type="checkbox"/> Marathi <input type="checkbox"/> Nepali <input type="checkbox"/> Pashto <input type="checkbox"/> Portuguese <input type="checkbox"/> Russian <input type="checkbox"/> Samoan <input type="checkbox"/> Serbian <input type="checkbox"/> Somali <input type="checkbox"/> Spanish <input type="checkbox"/> Swahili <input type="checkbox"/> Tamil <input type="checkbox"/> Telugu <input type="checkbox"/> Ukrainian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Wolof <input type="checkbox"/> Yiddish | <input type="checkbox"/> Different Preferred Language <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Prefers Not to Answer | | |
| If Different Preferred Language, please specify | | | |

Staff Completing (Printed Name):

Date:

| | |
|--|--|
| | |
|--|--|