

HMIS Intake Form for Emergency Shelter projects

Effective 10/01/2025

Intake Date	Entry Date	ServicePoint (HoH) ID:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Project Name
<input type="text"/>

HoH Name First	Middle	Last
<input type="text"/>	<input type="text"/>	<input type="text"/>
Suffix		Alias
<input type="text"/>		<input type="text"/>
Name Data Quality		
<input type="checkbox"/> Full Name Reported <input type="checkbox"/> Partial, Street or Code Name		
<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer		
Social Security Number		Date of Birth
<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 relation member <input type="checkbox"/> Other: non-relation member
Sex		
<input type="checkbox"/> Female <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Male <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"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> White <input type="checkbox"/> Black, African American, or African <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Hispanic/Latina/o <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Additional Race and Ethnicity detail: _____		

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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:	Which forms of health insurance do you have? (select multiple options if it applies):																
<table border="1"><tr><td></td><td></td><td>/</td><td></td><td></td><td>/</td><td></td><td></td></tr></table>			/			/			<table><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	
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<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:																	
Coverage Effective Date:	Enter Medicaid/Member ID:																
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		/			/												
Enter Member Group No:	Coverage End Date:																
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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="checkbox"/> GPD TIP housing subsidy <input type="checkbox"/> VASH housing subsidy <input type="checkbox"/> RRH or equivalent subsidy <input type="checkbox"/> HCV voucher (tenant or project based) (not dedicated) <input type="checkbox"/> Public housing unit <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Emergency Housing Voucher <input type="checkbox"/> Family Unification Program Voucher (FUP) <input type="checkbox"/> Foster Youth to Independence Initiative (FYI) <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> 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)? <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights	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	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	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"/> Client doesn't know

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<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	<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)	<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"/> 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 prefers not to answer
<input type="checkbox"/> N/A (Complete SECTION IV Below)	On the <u>night before</u> 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 <u>night before</u> 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)	On the <u>night before</u> 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 prefers not to answer

On the night before your previous stay, was that on the streets, in an Emergency Shelter, or Safe Haven? <input type="checkbox"/> No <input type="checkbox"/> Yes	Approximate date this episode of homelessness started: <div style="border: 1px solid black; padding: 2px; display: inline-block;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> </div>
Total number of times homeless 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 prefers not to answer	Total number of months homeless on the street, in emergency shelter, or SH in the past three years <div style="border-bottom: 1px solid black; width: 100px;"></div>

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"/> Yes (identify preferred language(s)) <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer																																															
Preferred Language(s)	<table border="0"><tr><td><input type="checkbox"/> Amharic</td><td><input type="checkbox"/> Luganda</td></tr><tr><td><input type="checkbox"/> Arabic</td><td><input type="checkbox"/> Mandarin</td></tr><tr><td><input type="checkbox"/> Bosnian</td><td><input type="checkbox"/> Marathi</td></tr><tr><td><input type="checkbox"/> Burmese</td><td><input type="checkbox"/> Nepali</td></tr><tr><td><input type="checkbox"/> Cambodian</td><td><input type="checkbox"/> Pashto</td></tr><tr><td><input type="checkbox"/> Chinese</td><td><input type="checkbox"/> Portuguese</td></tr><tr><td><input type="checkbox"/> Croatian</td><td><input type="checkbox"/> Russian</td></tr><tr><td><input type="checkbox"/> Dari</td><td><input type="checkbox"/> Samoan</td></tr><tr><td><input type="checkbox"/> English</td><td><input type="checkbox"/> Serbian</td></tr><tr><td><input type="checkbox"/> French</td><td><input type="checkbox"/> Somali</td></tr><tr><td><input type="checkbox"/> German</td><td><input type="checkbox"/> Spanish</td></tr><tr><td><input type="checkbox"/> Gujarati</td><td><input type="checkbox"/> Swahili</td></tr><tr><td><input type="checkbox"/> Haitian Creole</td><td><input type="checkbox"/> Tamil</td></tr><tr><td><input type="checkbox"/> Hawaiian</td><td><input type="checkbox"/> Telugu</td></tr><tr><td><input type="checkbox"/> Hindi</td><td><input type="checkbox"/> Ukrainian</td></tr><tr><td><input type="checkbox"/> Ilocano</td><td><input type="checkbox"/> Vietnamese</td></tr><tr><td><input type="checkbox"/> Japanese</td><td><input type="checkbox"/> Wolof</td></tr><tr><td><input type="checkbox"/> Karen</td><td><input type="checkbox"/> Yiddish</td></tr><tr><td><input type="checkbox"/> Kinyarwanda</td><td><input type="checkbox"/> Different Preferred Language</td></tr><tr><td><input type="checkbox"/> Korean</td><td><input type="checkbox"/> Client Doesn't Know</td></tr><tr><td><input type="checkbox"/> Lingala</td><td><input type="checkbox"/> Client Prefers Not to Answer</td></tr><tr><td><input type="checkbox"/> Client Prefers Not to Answer</td><td><input type="checkbox"/> Data Not Collected</td></tr><tr><td><input type="checkbox"/> Data Not Collected</td><td></td></tr></table>	<input type="checkbox"/> Amharic	<input type="checkbox"/> Luganda	<input type="checkbox"/> Arabic	<input type="checkbox"/> Mandarin	<input type="checkbox"/> Bosnian	<input type="checkbox"/> Marathi	<input type="checkbox"/> Burmese	<input type="checkbox"/> Nepali	<input type="checkbox"/> Cambodian	<input type="checkbox"/> Pashto	<input type="checkbox"/> Chinese	<input type="checkbox"/> Portuguese	<input type="checkbox"/> Croatian	<input type="checkbox"/> Russian	<input type="checkbox"/> Dari	<input type="checkbox"/> Samoan	<input type="checkbox"/> English	<input type="checkbox"/> Serbian	<input type="checkbox"/> French	<input type="checkbox"/> Somali	<input type="checkbox"/> German	<input type="checkbox"/> Spanish	<input type="checkbox"/> Gujarati	<input type="checkbox"/> Swahili	<input type="checkbox"/> Haitian Creole	<input type="checkbox"/> Tamil	<input type="checkbox"/> Hawaiian	<input type="checkbox"/> Telugu	<input type="checkbox"/> Hindi	<input type="checkbox"/> Ukrainian	<input type="checkbox"/> Ilocano	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Japanese	<input type="checkbox"/> Wolof	<input type="checkbox"/> Karen	<input type="checkbox"/> Yiddish	<input type="checkbox"/> Kinyarwanda	<input type="checkbox"/> Different Preferred Language	<input type="checkbox"/> Korean	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Lingala	<input type="checkbox"/> Client Prefers Not to Answer	<input type="checkbox"/> Client Prefers Not to Answer	<input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Data Not Collected	
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<input type="checkbox"/> Croatian	<input type="checkbox"/> Russian																																														
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<input type="checkbox"/> Haitian Creole	<input type="checkbox"/> Tamil																																														
<input type="checkbox"/> Hawaiian	<input type="checkbox"/> Telugu																																														
<input type="checkbox"/> Hindi	<input type="checkbox"/> Ukrainian																																														
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Staff Completing (Printed Name):

Date:

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