

# HMIS Standard Intake Form for HOPWA – TBRA (PSH) projects

Effective 10/01/25

Intake Date

|  |  |   |  |  |   |  |  |
|--|--|---|--|--|---|--|--|
|  |  | / |  |  | / |  |  |
|--|--|---|--|--|---|--|--|

Entry Date

|  |  |   |  |  |   |  |  |
|--|--|---|--|--|---|--|--|
|  |  | / |  |  | / |  |  |
|--|--|---|--|--|---|--|--|

ServicePoint  
(HoH) ID:

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

Project Name

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HoH First Name

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|--|
|  |
|--|

Middle

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

Last

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

Suffix

|  |
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|  |
|--|

Alias

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

☐ Full Name Reported

☐ Partial, Street or Code Name

☐ Client doesn't know

☐ Client prefers not to answer

Social Security  
Number:

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

☐ Full SSN reported

☐ Approx or Partial SSN

☐ Client doesn't know

☐ Client prefers not to answer

Date of Birth:

|  |  |   |  |  |   |  |  |
|--|--|---|--|--|---|--|--|
|  |  | / |  |  | / |  |  |
|--|--|---|--|--|---|--|--|

☐ Full DOB reported

☐ Approx or Partial DOB

☐ Client doesn't know

☐ Client prefers not to answer

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

Sex

☐ Female

☐ Male

☐ Client doesn't know

☐ Client prefers not to answer

☐ Data not collected

Race and Ethnicity (Select all that apply)

☐ American Indian, Alaska Native, or Indigenous

☐ Asian or Asian American

☐ Black, African American, or African

☐ Hispanic/Latina/o

☐ Middle Eastern or North African

☐ Additional Race and Ethnicity detail: \_\_\_\_\_

☐ Native Hawaiian or Pacific Islander

☐ White

☐ Client doesn't know

☐ 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: _____    |   |

## Housing Move-in Date

|  |   |  |  |   |  |  |
|--|---|--|--|---|--|--|
|  | / |  |  | / |  |  |
|--|---|--|--|---|--|--|

Based on the housing move-in date above, what county was the client housed in?

Unit Address

Unit City

Unit Zip

Number of bedrooms in unit

Number of people in unit

## 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):

- |                                   |  |
|-----------------------------------|--|
| <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:

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|  |  |
|--|--|
| <b>Coverage Effective Date:</b>  | <b>Enter Medicaid/Member ID:</b>   |
| <div> <div></div> <div></div> <div>/</div> <div></div> <div></div> <div>/</div> <div></div> <div></div> </div> |  |
| <b>Enter Member Group No:</b>  | <b>Coverage End Date:</b>  |
|  | <div> <div></div> <div></div> <div>/</div> <div></div> <div></div> <div>/</div> <div></div> <div></div> </div> |

| Disability  |   |   |   |   |   |   |
|---|---|---|---|---|---|---|
| <b>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?</b> |   |   |   |   |   |   |
| <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  | Mental Health   | Chronic Health Condition  | <input type="checkbox"/> Alcohol<br><input type="checkbox"/> Drugs<br><input type="checkbox"/> Both | Developmental   | HIV/AIDS  |
| Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:   | <input type="checkbox"/><br>Yes <input type="checkbox"/><br>No <input type="checkbox"/> | <input type="checkbox"/><br>Yes <input type="checkbox"/><br>No <input type="checkbox"/> | <input type="checkbox"/><br>Yes <input type="checkbox"/><br>No <input type="checkbox"/> | <input type="checkbox"/><br>Yes <input type="checkbox"/><br>No <input type="checkbox"/>             | <input type="checkbox"/><br>Yes <input type="checkbox"/><br>No <input type="checkbox"/> | <input type="checkbox"/><br>Yes <input type="checkbox"/><br>No <input type="checkbox"/> |

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

| Income   |                 |
|--|-----------------|
| <input type="checkbox"/> No/None at all <input type="checkbox"/> Yes (identify source and amounts)<br><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     |
| <b>Total Monthly Income:</b>   | <b>\$ _____</b> |

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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 prefers not to answer |
| Source   |   |
| <input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP)<br><input type="checkbox"/> Special Supplemental, Nutrition Program for Women, Infants, and Children (WIC)<br><input type="checkbox"/> TANF Child Care services<br><input type="checkbox"/> TANF transportation services<br><input type="checkbox"/> Other TANF-funded services<br><input type="checkbox"/> Other: _____ |   |

| 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)<br><br><input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher, Host Home shelter<br><br><input type="checkbox"/> Safe Haven   | <input type="checkbox"/> Foster care home or foster care group home<br><br><input type="checkbox"/> Hospital or other residential non-psychiatric medical facility<br><br><input type="checkbox"/> Jail, prison or juvenile detention facility<br><br><input type="checkbox"/> Long-term care facility or nursing home<br><br><input type="checkbox"/> Psychiatric hospital or other psychiatric facility<br><br><input type="checkbox"/> Substance abuse treatment facility or detox center  | <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth)<br><input type="checkbox"/> Residential project or halfway house with no homeless criteria<br><input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher<br><input type="checkbox"/> Host Home (non-crisis)<br><input type="checkbox"/> Staying or living in a friend's room, apartment, or house<br><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<br><input type="checkbox"/> Rental by client, with ongoing housing subsidy <ul style="list-style-type: none"> <li><input type="checkbox"/> GPD TIP housing subsidy</li> <li><input type="checkbox"/> VASH housing subsidy</li> <li><input type="checkbox"/> RRH or equivalent subsidy</li> <li><input type="checkbox"/> HCV voucher (tenant or project based) (not dedicated)</li> <li><input type="checkbox"/> Public housing unit</li> <li><input type="checkbox"/> Rental by client, with other ongoing housing subsidy</li> <li><input type="checkbox"/> Emergency Housing Voucher</li> <li><input type="checkbox"/> Family Unification Program Voucher (FUP)</li> <li><input type="checkbox"/> Foster Youth to Independence Initiative (FYI)</li> <li><input type="checkbox"/> Permanent Supportive Housing</li> <li><input type="checkbox"/> Other permanent housing dedicated for formerly homeless persons</li> </ul> <input type="checkbox"/> Owned by client, with ongoing housing subsidy<br><input type="checkbox"/> Owned by client, no ongoing housing subsidy | <input type="checkbox"/> Other<br><input type="checkbox"/> Worker unable to determine<br><input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer |
| <b>Length of Stay in Prior Living Situation (i.e. the literally homeless situation identified above)?</b><br><br><input type="checkbox"/> One night or less<br><input type="checkbox"/> Two to six nights<br><input type="checkbox"/> One week or more but less than one month<br><input type="checkbox"/> One month or more but less than 90 days<br><input type="checkbox"/> 90 days or more but less than one year<br><input type="checkbox"/> One year or longer | <b>Length of Stay in Prior Living Situation (i.e. the institutional situation identified above)?</b><br><br><input type="checkbox"/> One night or less<br><input type="checkbox"/> Two to six nights<br><input type="checkbox"/> One week or more but less than one month<br><input type="checkbox"/> One month or more but less than 90 days<br><input type="checkbox"/> 90 days or more but less than one year<br><input type="checkbox"/> One year or longer<br><br><b>Did you stay in the institutional situation less than 90 days?</b><br><br><input type="checkbox"/> Yes (If YES – Complete SECTION III)<br><input type="checkbox"/> No (If YES – Complete SECTION III) | <b>Length of Stay in Prior Living Situation (i.e. the housing situation identified above)?</b><br><br><input type="checkbox"/> One night or less<br><input type="checkbox"/> Two to six nights<br><input type="checkbox"/> One week or more but less than one month<br><input type="checkbox"/> One month or more but less than 90 days<br><input type="checkbox"/> 90 days or more but less than one year<br><input type="checkbox"/> One year or longer<br><br><b>Did you stay in the housing situation less than 7 nights?</b><br><br><input type="checkbox"/> Yes (If YES – Complete SECTION III)<br><input type="checkbox"/> No (If NO – End Homeless History Interview) | <b>Length of Stay in Prior Living Situation (i.e. the housing situation identified above)?</b><br><br><input type="checkbox"/> One night or less<br><input type="checkbox"/> Two to six nights<br><input type="checkbox"/> One week or more but less than one month<br><input type="checkbox"/> One month or more but less than 90 days<br><input type="checkbox"/> 90 days or more but less than one year<br><input type="checkbox"/> One year or longer<br><br><b>Did you stay in the housing situation less than 7 nights?</b><br><br><input type="checkbox"/> Yes (If YES – Complete SECTION III)<br><input type="checkbox"/> No (If NO – End Homeless History Interview)  | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer  |

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|  |  |  |  |   |
|--|--|--|--|---|
|  | <input type="checkbox"/> No (If NO – End Homeless History Interview)   |  |  |   |
| <input type="checkbox"/> N/A<br>(Complete SECTION IV Below)  | <b>On the <u>night before</u> entering the institutional situation did you stay on the streets, in emergency shelter or a safe haven?</b><br><br><input type="checkbox"/> Yes (If YES – Complete SECTION IV)<br><input type="checkbox"/> No (If NO – End Homeless History Interview) | <b>On the <u>night before</u> entering the housing situation did you stay on the streets, in emergency shelter or a safe haven?</b><br><br><input type="checkbox"/> Yes (If YES – Complete SECTION IV)<br><input type="checkbox"/> No (If NO – End Homeless History Interview) | <b>On the <u>night before</u> entering the housing situation did you stay on the streets, in emergency shelter or a safe haven?</b><br><br><input type="checkbox"/> Yes (If YES – Complete SECTION IV)<br><input type="checkbox"/> No (If NO – End Homeless History Interview) | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer |
| On the night <u>before your previous stay</u> , was that on the streets, in an Emergency Shelter, or Safe Haven?<br><input type="checkbox"/> No <input type="checkbox"/> Yes   |  | Approximate date this episode of homelessness started:<br><div style="border: 1px solid black; width: 150px; height: 20px; margin: 5px 0;"></div>  |  |   |
| Total <u>number of times</u> homeless on the street, in ES, or SH in the past three years<br><input type="checkbox"/> One time <input type="checkbox"/> Two times <input type="checkbox"/> Three times<br><input type="checkbox"/> Four times <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer |  | Total <u>number of months</u> homeless on the street, in emergency shelter, or SH in the past three years _____  |  |   |

|  |  |
|--|--|
| <b>Domestic Violence</b>   |  |
| <b>Are you, or have you been a survivor of domestic or intimate partner violence?</b><br><input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer   |  |
| <b>If YES, how long ago did you have this experience?</b><br><div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Within the past 3 months<br/> <input type="checkbox"/> 3 to 6 months ago<br/> <input type="checkbox"/> Client doesn't know         </div> <div> <input type="checkbox"/> 1 year ago or more<br/> <input type="checkbox"/> 6 months to 1 year ago<br/> <input type="checkbox"/> Client prefers not to answer         </div> </div> |  |
| <b>If Yes, are you currently fleeing?</b><br><input type="checkbox"/> No <input type="checkbox"/> Yes<br><input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer  |  |

|  |  |
|--|--|
| 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:                   |  |
| 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<br><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<br><input type="checkbox"/> Fleeing an abusive situation<br><input type="checkbox"/> Job Opportunities<br><input type="checkbox"/> Other<br><input type="checkbox"/> Client prefers not to answer |

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| HOPWA Project: Medical Assistance                                 |   |
|---|---|
| <b>Receiving AIDS Drug Assistance Program (ADAP)?</b>             |   |
| <input type="checkbox"/> No                                       | <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer |
| <b>If No, reason (for not receiving ADAP)?</b>                    |   |
| <input type="checkbox"/> Applied; decision pending                | <input type="checkbox"/> Applied; client not eligible   |
| <input type="checkbox"/> Client did not apply                     | <input type="checkbox"/> Insurance type N/A for this client   |
| <input type="checkbox"/> Client doesn't know                      | <input type="checkbox"/> Client prefers not to answer   |
| <b>Receiving Ryan White funded Medical or Dental Assistance?</b>  |   |
| <input type="checkbox"/> No                                       | <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer |
| <b>If No, reason (for not receiving Ryan White)?</b>              |   |
| <input type="checkbox"/> Applied; decision pending                | <input type="checkbox"/> Applied; client not eligible   |
| <input type="checkbox"/> Client did not apply                     | <input type="checkbox"/> Insurance type N/A for this client   |
| <input type="checkbox"/> Client doesn't know                      | <input type="checkbox"/> Client prefers not to answer   |
| <b>Has the participant been prescribed anti-retroviral drugs?</b> |   |
| <input type="checkbox"/> No                                       | <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer |

| HIV/AIDS  |  |
|---|--|
| <b>Start Date:</b>  | <b>End Date:</b>   |
| <input type="text"/> / <input type="text"/> / <input type="text"/>                          | <input type="text"/> / <input type="text"/> / <input type="text"/>   |
| If Yes for HIV/AIDS, does the client have a T-Cell (CD4) count available?                   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client prefers not to answer   |
| If Yes for HIV/AIDS and a T-Cell (CD4) count is available, what is the T-Cell (CD4) count?  |  |
| If Yes for HIV/AIDS and a T-Cell (CD4) is recorded above, how was the information obtained? | <input type="checkbox"/> Medical report <input type="checkbox"/> Client report<br><input type="checkbox"/> Other   |
| If Yes for HIV/AIDS, does the client have Viral Load Information available?                 | <input type="checkbox"/> Not Available <input type="checkbox"/> Available <input type="checkbox"/> Undetectable<br><input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer |
| If Yes for HIV/AIDS and Viral Load Information is available, what is the Viral Load?        |  |
| If Yes for HIV/AIDS and Viral Load is recorded above, how was the information obtained?     | <input type="checkbox"/> Medical report <input type="checkbox"/> Client report<br><input type="checkbox"/> Other   |

Staff Completing (Printed Name):

Date:

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