

HMIS Standard Intake Form for PREV projects

Effective 10/01/25

Intake Date

			/				/				
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Entry Date

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

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 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

Client doesn't know

Male

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: _____	

Health Insurance

<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Yes (If yes indicate all sources that apply 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:

Coverage Effective Date:

____ / ____ / ____

Enter Medicaid/Member ID:

Enter Member Group No:

Coverage End Date:

____ / ____ / ____

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
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	Physical <input type="checkbox"/>	Mental Health <input type="checkbox"/>	Chronic Health Condition <input type="checkbox"/>	Alcohol <input type="checkbox"/> Drugs <input type="checkbox"/> Both <input type="checkbox"/>	Developmental <input type="checkbox"/>	HIV/AIDS <input type="checkbox"/>
Expected to be of long-continued and indefinite						

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duration and substantially impairs ability to live independently:	Yes <input type="checkbox"/> No <input type="checkbox"/>					
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 ****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"/> Client doesn't know	<input type="checkbox"/> Yes (identify source and amounts) <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"/> Client doesn't know	<input type="checkbox"/> Yes (Identify source below) <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: _____	

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"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility	<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"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with ongoing housing subsidy <ul style="list-style-type: none">○ GPD TIP housing subsidy○ VASH housing subsidy○ RRH or equivalent subsidy	<input type="checkbox"/> Other <input type="checkbox"/> Worker unable to determine

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<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"/> 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"/> 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	<ul style="list-style-type: none"> <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 <p><input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy</p>	<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 <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)	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 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?

No Yes

Approximate date this episode of homelessness started:

 / / / / /

Total number of times homeless on the street, in ES, or SH in the past three years

One time Two times Three times
 Four times Client doesn't know Client prefers not to answer

Total number of months homeless on the street, in emergency shelter, or SH in the past three years: _____

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Are you, or have you been a survivor of domestic or intimate partner violence?

No Yes Client doesn't know Client prefers not to answer

If YES, how long ago did you have this experience?

Within the past 3 months 1 year ago or more
 3 to 6 months ago 6 months to 1 year ago
 Client doesn't know Client prefers not to answer

If Yes, are you currently fleeing?

No Yes
 Client doesn't know Client prefers not to answer

Translation Assistance Needed

No Yes (identify preferred language(s))
 Client doesn't know Client prefers not to answer

Preferred Language(s)

<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"/> Kinyarwand	<input type="checkbox"/> Different Preferred
<input type="checkbox"/> Korean	<input type="checkbox"/> Language
<input type="checkbox"/> Lingala	<input type="checkbox"/> Client Doesn't Know
<input type="checkbox"/> Client Prefers Not to Answer	
<input type="checkbox"/> Data Not Collected	

If Different Preferred Language, please specify

Foster Care	Zip Code of Last Permanent Address
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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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	<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			

Staff Completing (Printed Name):

Date: