

# HMIS Standard Update – Recovery Kentucky Entry

Effective 10/01/2025

**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 prefers not to answer

**Social Security  
Number:**

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☐ 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

**Marital Status**

☐ Divorced

☐ Married

☐ Partner/Significant Other

☐ Separated

☐ Single

☐ Widowed

**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)

- ☐ Woman (Girl, if child)
 ☐ Questioning  
☐ Man (Boy, if child)
 ☐ Different Identity  
☐ Culturally Specific Identity (e.g., Two-Spirit)
 ☐ Client doesn't know  
☐ Transgender
 ☐ Client prefers not to answer  
☐ Non-Binary  
☐ If Different Identity, Please Specify: \_\_\_\_\_

## Peer Mentor

☐ Yes
 ☐ No

## Education

### What is the highest level of school that you have completed?

- No Schooling Completed ☐
 Nursery School to 4<sup>th</sup> grade ☐
 5<sup>th</sup> grade or 6<sup>th</sup> grade ☐
 7<sup>th</sup> grade or 8<sup>th</sup> grade ☐  
 9<sup>th</sup> grade ☐
 10<sup>th</sup> grade ☐
 11<sup>th</sup> grade ☐
 12<sup>th</sup> grade, no diploma ☐  
 High school diploma ☐
 Post-secondary School ☐
 GED ☐
 Client Doesn't Know ☐  
 Client prefers not to answer ☐

## Domestic Violence

### 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

## 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?

☐ No
 ☐ Yes (indicate type(s) below)
 ☐ Client doesn't know
 ☐ 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"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	N/A	N/A
Expected to substantially impair ability to live independently:	N/A	N/A	N/A	N/A	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>

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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)				
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"> <li>○ GPD TIP housing subsidy</li> <li>○ VASH housing subsidy</li> <li>○ RRH or equivalent subsidy</li> <li>○ HCV voucher (tenant or project based) (not dedicated)</li> <li>○ Public housing unit</li> <li>○ Rental by client, with other ongoing housing subsidy</li> <li>○ Emergency Housing Voucher</li> <li>○ Family Unification Program Voucher (FUP)</li> <li>○ Foster Youth to Independence Initiative (FYI)</li> <li>○ Permanent Supportive Housing</li> <li>○ Other permanent housing dedicated for formerly homeless persons</li> </ul> <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
<b>Length of Stay in Prior Living Situation (i.e. the literally homeless situation identified above)?</b>  <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	<b>Length of Stay in Prior Living Situation (i.e. the institutional situation identified above)?</b>  <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	<b>Length of Stay in Prior Living Situation (i.e. the housing situation identified above)?</b>  <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	<b>Length of Stay in Prior Living Situation (i.e. the housing situation identified above)?</b>  <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"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer

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	<b>Did you stay in the institutional situation less than 90 days?</b>  <input type="checkbox"/> Yes (If YES – Complete SECTION III) <input type="checkbox"/> No (If NO – End Homeless History Interview)	<b>Did you stay in the housing situation less than 7 nights?</b>  <input type="checkbox"/> Yes (If YES – Complete SECTION III) <input type="checkbox"/> No (If NO – End Homeless History Interview)	<input type="checkbox"/> One year or longer  <b>Did you stay in the housing situation less than 7 nights?</b>  <input type="checkbox"/> Yes (If YES – Complete SECTION III) <input type="checkbox"/> No (If NO – End Homeless History Interview)	
<input type="checkbox"/> <b>N/A</b> (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>  <input type="checkbox"/> Yes (If YES – Complete SECTION IV) <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>  <input type="checkbox"/> Yes (If YES – Complete SECTION IV) <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>  <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 <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 date this episode of homelessness started: <div style="border: 1px solid black; width: 100px; 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 <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 <u>number of months</u> homeless on the street, in emergency shelter, or SH in the past three years <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div>

**County of last residence:**

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
<b>Total Monthly Income:</b>	
<b>\$</b>	

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	

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## Source:

- ☐ Supplemental Nutrition Assistance Program (SNAP)
- ☐ Special Supplemental, Nutrition Program for Women, Infants, and Children (WIC)
- ☐ TANF Child Care services
- ☐ TANF transportation services
- ☐ Other TANF-funded services
- ☐ Other: \_\_\_\_\_

## Health Insurance

- ☐ No
- ☐ Yes (identify source below)
- ☐ Client doesn't know
- ☐ Client prefers not to answer

## Source:

- ☐ Medicaid
- ☐ State Children's Health Insurance (KCHIP)
- ☐ Employer-Provided Health Insurance
- ☐ Private Pay Health Insurance
- ☐ Indian Health Services Program
- ☐ Medicare
- ☐ Veteran's Health Administration (VHA)
- ☐ Health Insurance obtained through COBRA
- ☐ State Health Insurance for Adults
- ☐ Other: \_\_\_\_\_

**Before you entered this recovery center what substance(s) do you believe were the most problematic for you? LIST UP TO 3 CATEGORIES IN THE ORDER OF PROBLEMS YOU EXPERIENCED.**

### Drug 1

- ☐ Alcohol (e.g. beer wine, distilled spirits)
- ☐ Opiates
- ☐ Subutex®/Suboxone or buprenorphine
- ☐ Sedatives, hypnotics, muscle relaxants, or tranquilizers
- ☐ Barbiturates
- ☐ Stimulants not prescribed for you (e.g. Methamphetamine, Dexedrine®, Adderall®)
- ☐ Cocaine/crack
- ☐ Inhalants
- ☐ Other: \_\_\_\_\_
- ☐ Marijuana (e.g., Hashish/Pot)
- ☐ Methadone
- ☐ Heroin
- ☐ Hallucinogens/psychedelics
- ☐ Synthetic/designer drugs

### Drug 2

- ☐ Alcohol (e.g. beer wine, distilled spirits)
- ☐ Opiates
- ☐ Subutex®/Suboxone or buprenorphine
- ☐ Sedatives, hypnotics, muscle relaxants, or tranquilizers
- ☐ Barbiturates
- ☐ Stimulants not prescribed for you (e.g. Methamphetamine, Dexedrine®, Adderall®)
- ☐ Cocaine/crack
- ☐ Inhalants
- ☐ Other: \_\_\_\_\_
- ☐ Marijuana (e.g., Hashish/Pot)
- ☐ Methadone
- ☐ Heroin
- ☐ Hallucinogens/psychedelics
- ☐ Synthetic/designer drugs

### Drug 3

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<input type="checkbox"/> Alcohol (e.g. beer wine, distilled spirits)	<input type="checkbox"/> Marijuana (e.g., Hashish/Pot)
<input type="checkbox"/> Opiates	<input type="checkbox"/> Methadone
<input type="checkbox"/> Subutex®/Suboxone or buprenorphine	<input type="checkbox"/> Heroin
<input type="checkbox"/> Sedatives, hypnotics, muscle relaxants, or tranquilizers	
<input type="checkbox"/> Barbiturates	
<input type="checkbox"/> Stimulants not prescribed for you (e.g. Methamphetamine, Dexedrine®, Adderall®)	
<input type="checkbox"/> Cocaine/crack	<input type="checkbox"/> Hallucinogens/psychedelics
<input type="checkbox"/> Inhalants	<input type="checkbox"/> Synthetic/designer drugs
<input type="checkbox"/> Other:	

## Legal Information

### Primary Source Referral?

Casey's Law <input type="checkbox"/>	Clinic/Hospital <input type="checkbox"/>	Community Health Program <input type="checkbox"/>	Court <input type="checkbox"/>
DOC/Pre-Trial Diversion <input type="checkbox"/>	Drug Court <input type="checkbox"/>	Drug Court referred thru DOC <input type="checkbox"/>	Family/Friend <input type="checkbox"/>
Needle Exchange Program <input type="checkbox"/>	Other <input type="checkbox"/>	Other RKY Center <input type="checkbox"/>	Probation/Parole-DOC <input type="checkbox"/>
Probation/Parole-Non DOC <input type="checkbox"/>	Scholarship <input type="checkbox"/>	Self <input type="checkbox"/>	Self-Help Group <input type="checkbox"/>
Sponsor <input type="checkbox"/>	Trtmt/Subst. Abuse Facility <input type="checkbox"/>		

### Referred by DOC?

☐ No ☐ Yes

### Have you ever been convicted of a felony?

☐ No ☐ Yes

### What RKY Program Component is the client in at exit?

☐ SOS  
☐ MT1  
☐ MT2  
☐ Phase 1  
☐ Phase 2

Staff Completing (Printed Name):

Date:

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