

# HMIS Standard Intake Form for RHY projects

Effective 10/01/2021

**Intake Date**

|  |  |   |  |  |   |  |  |
|--|--|---|--|--|---|--|--|
|  |  | / |  |  | / |  |  |
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**Entry Date**

|  |  |   |  |  |   |  |  |
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|  |  | / |  |  | / |  |  |
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**ServicePoint**

**(HoH) ID:**

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

**Project Name**

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

**HoH First Name**

**Middle**

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

**Last**

**Suffix**

**Alias**

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

Full Name Reported

Partial, Street or Code Name

Client doesn't know

Client Refused

**Social Security Number:**

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

Full SSN reported

Approx or Partial SSN

Client doesn't know

Client refused

**Date of Birth:**

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

Full DOB reported

Approx or Partial DOB

Client doesn't know

Client refused

**Race (Select all that apply)**

American Indian, Alaska Native, or Indigenous

Black, African American, or African

Native Hawaiian or Pacific Islander

Asian

White

Client doesn't know

Client refused

**Gender**

Female

Male

A gender other than singularly female or male (e.g., non-binary, genderfluid, agender, culturally specific gender)

Transgender

Questioning

Client doesn't know

Client refused

**Ethnicity**

Non-Hispanic/Non-Latin(o)(a)(x)

Hispanic/Latin(a)(o)(x)

Client doesn't know

Client refused

**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

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| Health Insurance                                                   |                                                                  |
|--------------------------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> No                                        | <input type="checkbox"/> Client doesn't know                     |
| <input type="checkbox"/> Yes (identify source below)               | <input type="checkbox"/> Client refused                          |
| Source:                                                            |                                                                  |
| <input type="checkbox"/> Medicaid                                  | <input type="checkbox"/> Medicare                                |
| <input type="checkbox"/> State Children's Health Insurance (KCHIP) | <input type="checkbox"/> VA Medical Services                     |
| <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: _____                            |

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

| 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 refused                    |
| 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>                                         |                                                            |

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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 refused              |
| 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 Current Living Situation – current to project entry                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| (Select one Living Situation and answer the corresponding questions in the order in which they appear)                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                             |
| Start Date                                                                                                                                                                                                                                                                                                        | End Date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Information Date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                             |
| <input type="text"/>                                                                                                                                                                                                                                                                                              | <input type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                             |
| (Select one Living Situation and answer the corresponding questions in the order in which they appear)                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                             |
| Homeless Situation                                                                                                                                                                                                                                                                                                | Institutional Situation                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Transitional/Permanent Housing Situation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Other                                                                                                                                                                                       |
| <input type="checkbox"/> Place not meant for habitation (e.g. a vehicle, abandoned building, bus/train/subway station, airport, anywhere outside).<br><br><input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher<br><br><input type="checkbox"/> Safe Haven | <input type="checkbox"/> Foster care home or foster 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"/> 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"/> Transitional housing for homeless persons (including homeless youth)<br><input type="checkbox"/> Host Home (non-crisis)<br>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<br><input type="checkbox"/> Rental by client, with GPD TIP housing subsidy<br><input type="checkbox"/> Rental by client, with VASH housing subsidy<br><input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons<br><input type="checkbox"/> Rental by client, with RRH or equivalent subsidy<br><input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based)<br><input type="checkbox"/> Rental by client in a public housing unit<br><input type="checkbox"/> Rental by client, no ongoing housing subsidy<br><input type="checkbox"/> Rental by client with other ongoing housing subsidy<br><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><br><input type="checkbox"/> Worker unable to determine<br><input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client refused |
| Is client going to have to leave their current living situation within 14 days?<br><br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                   | <b>If yes, answer the following questions.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                             |
| Has a subsequent residence been identified?<br><br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                       | Does individual or family have resources or support networks to obtain other permanent housing?<br><br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                         | Has the client had a lease or ownership interest in a permanent housing unit in the last 60 days?<br><br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Has the client moved 2 or more times in the past 60 days?<br><br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                   |

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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)                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                         |
| Literally Homeless Situation                                                                                                                                                                                                                                                                                                                                                                                                                                     | Institutional Situation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Transitional/Permanent Housing Situation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Other                                                                                   |
| <input type="checkbox"/> Place not meant for habitation (e.g. a vehicle, abandoned building, bus/train/subway station, airport, anywhere outside).<br><input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher<br><input type="checkbox"/> Safe Haven                                                                                                                                                        | <input type="checkbox"/> Foster care home or foster group home<br><input type="checkbox"/> Hospital or other residential non-psychiatric medical facility<br><input type="checkbox"/> Jail, prison or juvenile detention facility<br><input type="checkbox"/> Long-term care facility or nursing home<br><input type="checkbox"/> Psychiatric hospital or other psychiatric facility<br><input type="checkbox"/> Substance abuse treatment facility or detox center                                                                                                                                                                                                              | <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"/> Transitional housing for homeless persons (including homeless youth)<br><input type="checkbox"/> Host Home (non-crisis) 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<br><input type="checkbox"/> Rental by client, with GPD TIP housing subsidy<br><input type="checkbox"/> Rental by client, with VASH housing subsidy<br><input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons<br><input type="checkbox"/> Rental by client, with RRH or equivalent subsidy<br><input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based)<br><input type="checkbox"/> Rental by client in a public housing unit<br><input type="checkbox"/> Rental by client, no ongoing housing subsidy<br><input type="checkbox"/> Rental by client with other ongoing housing subsidy<br><input type="checkbox"/> Owned by client, with ongoing housing subsidy<br><input type="checkbox"/> Owned by client, no ongoing housing subsidy | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client refused |
| <b>Length of Stay in Prior Living Situation (i.e. the literally homeless situation identified above)?</b><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><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><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><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><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 refused |
| <input type="checkbox"/> N/A<br>(Complete SECTION IV Below)                                                                                                                                                                                                                                                                                                                                                                                                      | <b>On the night before entering the institutional situation did you stay on the streets, in emergency shelter or a safe haven?</b><br><input type="checkbox"/> Yes (If YES – Complete SECTION IV)<br><input type="checkbox"/> No (If NO – End Homeless History Interview)                                                                                                                                                                                                                                                                                                                                                                                                        | <b>On the night before entering the housing situation did you stay on the streets, in emergency shelter or a safe haven?</b><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 refused |

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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|
| 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 start of homelessness:<br><table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 12.5%; height: 15px;"> </td> <td style="width: 12.5%; height: 15px;"> </td> <td style="width: 12.5%; height: 15px;"> </td> <td style="width: 12.5%; height: 15px;"> </td> <td style="width: 12.5%; height: 15px;"> </td> <td style="width: 12.5%; height: 15px;"> </td> <td style="width: 12.5%; height: 15px;"> </td> <td style="width: 12.5%; height: 15px;"> </td> </tr> </table> |  |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |  |  |  |  |  |  |  |
| Total <u>number of times homeless</u> 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 refused | Total number of <u>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 refused                                                                                                           |  |
| <b>If YES, how long ago did you have this experience?</b><br><input type="checkbox"/> Within the past 3 months <input type="checkbox"/> 1 year ago or more<br><input type="checkbox"/> 3 to 6 months ago <input type="checkbox"/> 6 months to 1 year ago<br><input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |  |
| <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 refused                                                                                                                                                    |  |

|                                                                                                                                                                                                                                                 |  |  |  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|
| <b>Zip Code of Last Permanent Address</b>                                                                                                                                                                                                       |  |  |  |  |
| <table border="1" style="width: 100%;"> <tr> <td style="width: 25%; height: 20px;"> </td> <td style="width: 25%; height: 20px;"> </td> <td style="width: 25%; height: 20px;"> </td> <td style="width: 25%; height: 20px;"> </td> </tr> </table> |  |  |  |  |
|                                                                                                                                                                                                                                                 |  |  |  |  |

|                                                                                |                                                                                                                                                                                                                                              |
|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| In the last 2 years, have you lived anywhere other than this county/community? | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused                                                                                             |
| Where did you move from?                                                       | <input type="checkbox"/> A different Kentucky County<br><input type="checkbox"/> Another part of the US<br><input type="checkbox"/> Other                                                                                                    |
| If a different Kentucky County, please specify:                                |                                                                                                                                                                                                                                              |
| If Another part of the US, please specify state:                               |                                                                                                                                                                                                                                              |
| If other location, please specify:                                             |                                                                                                                                                                                                                                              |
| 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 refused                                                                                             |
| 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 refused |

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| RHY Required Questions:                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Referral Source</b>                                                                              | <input type="checkbox"/> Self-Referral<br><input type="checkbox"/> Individual: Parent/Guardian/Relative/Friend/Foster Parent/Other Individual<br><input type="checkbox"/> Outreach Project<br><input type="checkbox"/> Temporary Shelter<br><input type="checkbox"/> Residential Project<br><input type="checkbox"/> Hotline<br><input type="checkbox"/> Child Welfare/CPS<br><input type="checkbox"/> Juvenile Justice<br><input type="checkbox"/> Law Enforcement/Police<br><input type="checkbox"/> Mental Hospital<br><input type="checkbox"/> School<br><input type="checkbox"/> Other Organization<br><input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client refused<br><input type="checkbox"/> Data not collected |
| <b>Youth Eligible for RHY Services</b>                                                              | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>If No for "Youth Eligible for RHY Services", Reason why services are not funded by BCP grant</b> | <input type="checkbox"/> Out of Age range<br><input type="checkbox"/> Ward of the State – Immediate Reunification<br><input type="checkbox"/> Ward of the Criminal Justice System – Immediate Reunification<br><input type="checkbox"/> Other                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>If Yes, for "Youth Eligible for RHY Services", Runaway youth</b>                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Data not collected<br><input type="checkbox"/> Client doesn't know                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Sexual Orientation</b>                                                                           | <input type="checkbox"/> Heterosexual<br><input type="checkbox"/> Gay<br><input type="checkbox"/> Lesbian<br><input type="checkbox"/> Bisexual<br><input type="checkbox"/> Questioning/Unsure<br><input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

## Education

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

|                                                          |                                                                       |                                             |                                                      |
|----------------------------------------------------------|-----------------------------------------------------------------------|---------------------------------------------|------------------------------------------------------|
| Less than Grade 5<br><input type="checkbox"/>            | Grade 5-6<br><input type="checkbox"/>                                 | Grades 7-8<br><input type="checkbox"/>      | Grades 9-11<br><input type="checkbox"/>              |
| Grade 12/High School Diploma<br><input type="checkbox"/> | School program does not have grade levels<br><input type="checkbox"/> | GED<br><input type="checkbox"/>             | Some college<br><input type="checkbox"/>             |
| Associate degree<br><input type="checkbox"/>             | Bachelor's degree<br><input type="checkbox"/>                         | Graduate degree<br><input type="checkbox"/> | Vocational certification<br><input type="checkbox"/> |
| Client doesn't know<br><input type="checkbox"/>          | Client refused<br><input type="checkbox"/>                            |                                             |                                                      |

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## School Status

|                                                        |                                                          |                                                   |                                            |                                                |
|--------------------------------------------------------|----------------------------------------------------------|---------------------------------------------------|--------------------------------------------|------------------------------------------------|
| Attending School Regularly<br><input type="checkbox"/> | Attending School Irregularly<br><input type="checkbox"/> | Graduated High School<br><input type="checkbox"/> | Obtained GED<br><input type="checkbox"/>   | Dropped Out<br><input type="checkbox"/>        |
| Suspended<br><input type="checkbox"/>                  | Expelled<br><input type="checkbox"/>                     | Client doesn't know<br><input type="checkbox"/>   | Client refused<br><input type="checkbox"/> | Data not collected<br><input type="checkbox"/> |

## Employment

Are you presently employed?

Yes                       No                       Client doesn't know                       Client refused

If employed, is this permanent, temporary or seasonal work?

Full-time                       Part-time                       Seasonal/sporadic (including day labor)

Data no collected

If No, why not Employed?

Looking for work                       Unable to work                       Not Looking for work                       Data no collected

## Health Status

|                              |                                                                                                                                            |                                                                                                                                                                         |
|------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>General Health Status</b> | <input type="checkbox"/> Excellent<br><input type="checkbox"/> Very good<br><input type="checkbox"/> Good<br><input type="checkbox"/> Fair | <input type="checkbox"/> Poor<br><input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client refused<br><input type="checkbox"/> Data not collected |
| <b>Dental Health Status</b>  | <input type="checkbox"/> Excellent<br><input type="checkbox"/> Very good<br><input type="checkbox"/> Good<br><input type="checkbox"/> Fair | <input type="checkbox"/> Poor<br><input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client refused<br><input type="checkbox"/> Data not collected |
| <b>Mental Health Status</b>  | <input type="checkbox"/> Excellent<br><input type="checkbox"/> Very good<br><input type="checkbox"/> Good<br><input type="checkbox"/> Fair | <input type="checkbox"/> Poor<br><input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client refused<br><input type="checkbox"/> Data not collected |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                  |                                                                                               |  |  |  |  |  |  |  |  |                                                                                                      |                                                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| Are you pregnant?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                   | Formerly a Ward of Child Welfare/Foster Care Agency?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Formerly Juvenile Justice System?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |  |  |  |  |  |                                                                                                      |                                                                                                      |
| If yes, projected birth date<br><table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> </tr> </table> |                                                                                                                  |                                                                                               |  |  |  |  |  |  |  |  | If yes, number of years or months (if less than years)<br><input style="width: 100px;" type="text"/> | If yes, number of years or months (if less than years)<br><input style="width: 100px;" type="text"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                  |                                                                                               |  |  |  |  |  |  |  |  |                                                                                                      |                                                                                                      |

## Family Critical Issues

|                                                   |                              |                             |                                         |
|---------------------------------------------------|------------------------------|-----------------------------|-----------------------------------------|
| Unemployment – Family member                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Client refused |
| Mental Health Disorder – Family member            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Client refused |
| Physical Disability – Family Member               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Client refused |
| Alcohol or Substance Use Disorder – Family Member | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Client refused |
| Insufficient Income to Support Youth              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Client refused |
| Incarcerated Parent of Youth                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Client refused |

# HMIS Standard Intake Form for RHY projects

Effective 10/01/2021

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**Date of Engagement – Street Outreach Only**

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

**Staff Completing (Printed Name):**

**Date:**

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