

# HMIS Standard Intake Form for TBRA projects

Effective 10/01/2021

**Intake Date**

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

**Entry Date**

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

**ServicePoint  
(HoH) ID:**

--	--	--	--	--	--	--	--

**Project Name**

--

**HoH First Name**

--

**Middle**

--

**Last**

--

**Suffix**

--

**Alias**

--

Full Name Reported

Partial, Street or Code Name

Client doesn't know

Client 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 or Asian American

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-Latino(a)(o)(x)

Hispanic/Latino(a)(o)9x)

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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Housing Move-in Date	<input type="text"/> / <input type="text"/> / <input type="text"/>
Based on the housing move-in date above, what county was the client housed in?	
Unit Address	
Unit City	
Unit Zip	
Number of bedrooms in unit	
Number of people in unit	

<b>Health Insurance</b>	
<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Yes (identify source below)	<input type="checkbox"/> Client
<b>Source</b>	
<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: _____

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

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**\*\*Only answer the following questions for Adults and HoH. \*\***

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>	
<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 refused
Source	
<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) <input type="checkbox"/> Special Supplemental, Nutrition Program for Women, Infants, and Children (WIC) <input type="checkbox"/> TANF Child Care services <input type="checkbox"/> TANF transportation services <input type="checkbox"/> Other TANF-funded services <input type="checkbox"/> Other: _____	

Client's Prior Living Situation - Prior to Project Entry			
(Select one Living Situation and answer the corresponding questions in the order in which they appear)			
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).  <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher  <input type="checkbox"/> Safe Haven	<input type="checkbox"/> Foster care home or foster 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"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Host Home (non-crisis) 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, with GPD TIP housing subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused

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	<input type="checkbox"/> Psychiatric hospital or other psychiatric facility  <input type="checkbox"/> Substance abuse treatment facility or detox center	<input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons <input type="checkbox"/> Rental by client, with RRH or equivalent subsidy <input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based) <input type="checkbox"/> Rental by client in a public housing unit <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client with other ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy	
<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>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>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>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"/> Client doesn't know <input type="checkbox"/> Client refused
<input type="checkbox"/> N/A (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)	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused

On the night before <u>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 start of homelessness: <input type="text"/> / <input type="text"/> / <input type="text"/>
Total <u>number of times homeless</u> 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 refused	Total <u>number of months</u> homeless on the street, in emergency shelter, or SH in the past three years _____

<b>Domestic Violence</b>			
<b>Are you, or have you been a survivor of domestic or intimate partner violence?</b>			
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/>
Client refused			

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<b>If YES, how long ago did you have this experience?</b>	
<input type="checkbox"/> Within the past 3 months	<input type="checkbox"/> 1 year ago or more
<input type="checkbox"/> 3 to 6 months ago	<input type="checkbox"/> 6 months to 1 year ago
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
<b>If Yes, are you currently fleeing?</b>	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused

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

<b>% of county median income</b>	<input type="checkbox"/> 0% to 30%
	<input type="checkbox"/> 31% to 50%
	<input type="checkbox"/> 51% to 80%
	<input type="checkbox"/> over 80%
	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> 100% - below
	<input type="checkbox"/> 101% - 150%
	<input type="checkbox"/> 151% - 200%
	<input type="checkbox"/> over 200%
	<input type="checkbox"/> Client Refused

<b>Staff Completing (Printed Name):</b>	<b>Date:</b>
<input type="text"/>	<input type="text"/>