HMIS Intake and Enrollment Form
Outreach

Client ID: _____

Program Start Date: _____

Staff Completing HMIS Form: _____

Identification *- All fields required unless otherwise noted*

First Name _____ **Middle Name** _____

Last Name _____ **Suffix** _____

Name Data Quality: Did the client provide their full name?	**Social Security Number (SSN)**	**Birth Date (DOB)**
□ Full Name Reported □ Partial, street name, or code name reported □ Client Doesn't Know □ Client Refused	_____-_____-_____ □ Full SSN reported □ Approximate or partial SSN reported □ Client Doesn't Know □ Client Refused	_____/_____/_____ □ Approximate or partial DOB reported □ Full DOB reported □ Client Doesn't Know □ Client Refused

Basic Demographics – All fields required unless otherwise noted

Race (Check all that apply)	**Ethnicity**
□ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Other Pacific Islander □ White □ Client Doesn't Know □ Client Refused	□ Hispanic/Latino □ Non-Hispanic/ Non-Latino □ Client Doesn't Know □ Client Refused
Gender	**Disabling Condition**
□ Male □ Female □ Trans Male (Female to Male) □ Trans Female (Male to Female) □ Non-Conforming (Not exclusively male or Female) □ Client Doesn't Know □ Client Refused	□ Yes □ No □ Client Doesn't Know □ Client Refused **Veteran (Have you ever served in the U.S. Military?)** ***18 and Over*** □ Yes □ No □ Don't Know □ Client Refused

Date of Engagement

_____/_____/_____

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Universal Data Assessment	
Client Location: CA-510 – Turlock/ Modesto/ Stanislaus County CoC	
Living Situation: (FOR ALL PERSONS ENTERING EMERGENCY SHELTER, SAFE HAVEN, AND STREET OUTREACH)	
Question	Check One Answer
1. **What was the situation you were living in immediately prior to project entry? (The night before)** ***(Type of residence)***	□ Place not meant for habitation □ Emergency shelter, including hotel or motel paid for with emergency shelter □ Safe Haven □ Interim Housing □ Foster care home or foster care group home □ Hospital or other residential non-psychiatric medical facility □ Jail, prison or juvenile detention facility □ Long-term care facility or nursing home □ Psychiatric hospital or other psychiatric facility □ Substance abuse treatment facility or detox center □ Hotel or motel paid for without emergency shelter voucher □ Owned by client, no ongoing housing subsidy □ Owned by client, with ongoing housing subsidy □ Permanent housing (Other than RRH) for formerly homeless persons □ Rental by client, no ongoing housing subsidy □ Rental by client, with VASH subsidy □ Rental by client, with GPD TIP subsidy □ Rental by client, with other ongoing housing subsidy (Including RRH) □ Residential project or halfway house with no homeless criteria □ Staying or living in a family member's room, apartment or house □ Staying or living in a friend's room, apartment or house □ Transitional housing for homeless persons (including homeless youth) □ Client doesn't know □ Client refused
2. How long was the client staying in that place? ***(Length of stay in prior living situation)***	□ One night or less □ Two to six nights □ One week or more, but less than one month □ One month or more, but less than 90 days □ 90 days or more, but less than one year □ One year or longer □ Client doesn't know □ Client refused
3. What approximate date did you start living on the streets, emergency shelter, or safe haven? *(Approximate date started)*	_____/_____/_____
Regardless of where they stayed last night number of times the client has been on the streets, in ES, or SH in the past three years including today	□ One Time □ Two Times □ Three Times □ Four or more times □ Client Doesn't Know □ Client Refused
Total Number of months homeless on the streets, in ES, or SH in the past three years	□ One Month (this time is the first month) □ 2-12 (_____ months) □More than 12 □ Client Doesn't Know □ Client Refused

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Health Insurance			
□ Yes (Enter the Source)	□ No	□ Client Doesn't Know	□ Client Refused

Health Insurance Sources	
□ Private Pay Health Insurance □ Medicare □ MEDICAID □ State Children's Health Insurance(SCHIP) □ VA Medical Services	□ Employer Provided Health Insurance □ Health Insurance obtained through COBRA □ State Health Insurance Adults (Medi-cal) □ Indian Health Services Program Other:_____

Barriers:		
	Barrier Present	**Condition is Indefinite**
Alcohol Abuse	□ Yes □ No □ Don't Know □ Client Refused	□ Yes □ No □ Don't Know □ Client Refused
Chronic Health Condition	□ Yes □ No □ Don't Know □ Client Refused	□ Yes □ No □ Don't Know □ Client Refused
Development Disability	□ Yes □ No □ Don't Know □ Client Refused	□ Yes □ No □ Don't Know □ Client Refused
Drug Abuse	□ Yes □ No □ Don't Know □ Client Refused	□ Yes □ No □ Don't Know □ Client Refused
HIV/AIDS	□ Yes □ No □ Don't Know □ Client Refused	□ Yes □ No □ Don't Know □ Client Refused
Mental health	□ Yes □ No □ Don't Know □ Client Refused	□ Yes □ No □ Don't Know □ Client Refused
Physical Disability	□ Yes □ No □ Don't Know □ Client Refused	□ Yes □ No □ Don't Know □ Client Refused

Domestic Violence	
Is the client a domestic violence victim/survivor?	□ Yes (Answer questions below) □ No □ Client Doesn't Know □ Client Refused
If yes, How long ago did you have this experience?	□ Within the past 3 months □ 3 months to 6 months ago □ 6 months to one year □ One year ago or more □ Client Doesn't Know □ Client Refused
If yes, are you currently fleeing?	□ Yes (Answer questions below) □ No □ Client Doesn't Know □ Client Refused

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Financial Assessment (Check all that Apply and Enter amount)			
Income Source (Check all that apply) □ Yes (Check all Sources that Apply) □ No □ Client Doesn't Know □ Client Refused	**Stated Income (Monthly)**	**Non-Cash Resources** (Check all that apply) □ Yes (Check all Sources that Apply) □ No □ Client Doesn't Know □ Client Refused	**Stated Amounts (Monthly)**
□ Earned Income *(employment wages / cash)*	$	□ Special Supplemental nutritional Program Women and Children	$
□ Unemployment Insurance	$	□ Food Stamps (CalFresh) SNAP	$
□ Supplemental Security Income (SSI)	$	□ CalWorks Child Care/TANF Child Care Services	$
□ Social Security Disability Income (SSDI)	$	□ CalWorks Transportation (TANF)	$
□ Private Disability Insurance	$	□ Other CalWorks-Funded Services (TANF)	$
□ Workers Compensation	$	□ Other	$
□ VA Service-Connected Disability Compensation	$		
□ VA Non-Service-Connected Disability Pension	$		
□ Pension or Retirement income from a job	$		
□ TANF	$		
□ General Assistance	$		
□ Retirement (Social Security)	$		
□ Child Support	$		
□ Alimony or other Spousal Support	$		
□ Other Income	$		

Contact	
Date of Contact (E.G. 05/24/2010)	_____/_____/_____
As of today, is the client staying on the Streets, Emergency Shelter, or Safe Haven?	□ Yes □ No □ Worker unable to determine