

HMIS Intake and Enrollment Form PATH

Client HMIS ID # _____

Client DMH #: _____

Program Start Date:
(POR1 Date) _____

Staff Completing HMIS Form: _____

Identification - All fields required unless otherwise noted

BHRS/HMIS ROI Completion Date _____/_____/_____

First Name _____ Middle Name _____

Last Name _____ Suffix _____

Name Data Quality: Did the client provide their full name?	Social Security Number (SSN) And Data Quality	Date of Birth (DOB) and Data Quality
<input type="checkbox"/> Full Name Reported <input type="checkbox"/> Partial, street name, or code name reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	_____/_____/_____ <input type="checkbox"/> Full SSN reported <input type="checkbox"/> Approximate or partial SSN reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	_____/_____/_____ <input type="checkbox"/> Full DOB reported <input type="checkbox"/> Approximate or partial DOB reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Basic Demographics - All fields required unless otherwise noted

Race (Check all that apply)	Ethnicity
<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Gender	Program Enrollment (Ask the client where he/she stayed last night)
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans Female (Male to Female) <input type="checkbox"/> Trans Male (Female to Male) <input type="checkbox"/> Gender Non-Conforming (Not exclusively male or female) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Outreach Place not meant for habitation (i.e. streets, under bridges, camps, camp grounds, abandoned buildings, buildings meant for animals, vehicles, public areas) <input type="checkbox"/> Supportive Services (Select this if the client's answer DOES NOT fall under "Place not meant for habitation")

Veteran - Have you ever served in the U.S. Military?	Date of Engagement (O/R-Intake completed)
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	_____/_____/_____ Date of PATH Status Determination (POR 3 Date) (SMI confirmed, client homeless/at risk, client agrees to services and IRP completed/signed) _____/_____/_____

Relationship to Head of Household	Client Became Enrolled in PATH (POR3)
<input type="checkbox"/> Self <input type="checkbox"/> Head of Household's Child <input type="checkbox"/> Head of Household's Spouse or Partner <input type="checkbox"/> Head of Household's other Relation Member (Other relation to head of household) <input type="checkbox"/> Other: Non-relation Member	<input type="checkbox"/> Yes (Only select when there is a PATH Status Determination Date above) <input type="checkbox"/> No (Select options below) <ul style="list-style-type: none"> <input type="checkbox"/> Client was found ineligible for PATH (Confirmed no SMI or client is not homeless/at risk of homelessness) <input type="checkbox"/> Client was not enrolled for another reason (i.e. Unable to confirm SMI, client left the program, IRP not yet completed)

Outreach (Place not meant for habitation) - Complete Universal Data Assessment on Page 2

Supportive Services - Complete Universal Data Assessment on Page 3

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Client DMH #: _____

Universal Data Assessment		
Client Location: CA-510 – Turlock/ Modesto/ Stanislaus County CoC		
Living Situation – Only complete this page if you selected “Outreach” under Program Enrollment on Page 1		
Question	Check One Answer	
1. What was your living situation last night?	<input type="checkbox"/> Place not meant for habitation	
2. How long were you staying in that place? <i>(Length of stay in prior living situation)</i>	<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 <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
3. What approximate date did you start living in a place not meant for habitation? <i>(Approximate date started)</i>	_____ / _____ / _____	
<i>Regardless of where you stayed last night, how many times have you been on the streets, in Emergency Shelter (ES), or Safe Haven (SH) in the past three years including today?</i>	<input type="checkbox"/> One Time <input type="checkbox"/> Two Times <input type="checkbox"/> Three Times	<input type="checkbox"/> Four or more times <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
<i>Total number of months homeless on the streets, in ES, or SH in the past three years?</i>	<input type="checkbox"/> One Month (this time is the first month) <input type="checkbox"/> 2-12 (____ months)	<input type="checkbox"/> More than 12 <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Section Complete - Continue to Wellness Assessment on Page 4

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Client DMH #: _____

Universal Data Assessment

Client Location: CA-510 – Turlock/ Modesto/ Stanislaus County CoC

Living Situation – Only complete this section if you selected “Supportive Services” under Program Enrollment on Page 1

<p>1. What was the type of residence you were living in immediately prior to project entry? (The night before) Literally Homeless Situations</p> <ul style="list-style-type: none"> <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter (i.e. Mission, Respite, CHSS) <input type="checkbox"/> Safe Haven <input type="checkbox"/> Interim Housing 	<p>2. Length of stay in prior living situation?</p> <ul style="list-style-type: none"> <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 <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused 	<p>3. Did you stay less than... Not Applicable (Continue to questions 5-7 on Page 4)</p>
<p>1. What was the living Situation you were living in immediately prior to project entry? Institutional Situations</p> <ul style="list-style-type: none"> <input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail, prison or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center 	<p>2. Did you stay less than...</p> <p>90 Days</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes (Continue to questions 3-4) <input type="checkbox"/> No (Proceed Wellness Assessment on Page 4) 	<p>3. Length of stay in prior living situation? For Institutional Situations:</p> <ul style="list-style-type: none"> <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 <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
<p>1. What was the living Situation you were living in immediately prior to project entry? Transitional & Permanent Housing Situations</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Permanent housing (Other than RRH) for formerly homeless persons <input type="checkbox"/> Rental by client, no ongoing housing Subsidy (i.e. Room and Board) <input type="checkbox"/> Rental by client, with VASH subsidy <input type="checkbox"/> Rental by client, with GPD TIP subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy (Including RRH) <input type="checkbox"/> Residential project or halfway house with no homeless criteria (i.e. Sober Living) <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> Staying or living in a friend's room, apartment or house <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused 	<p>2. Did you stay less than...</p> <p>7 Nights</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes (Continue to questions 3-4) <input type="checkbox"/> No (Continue to question 3 then proceed to Wellness Assessment on Page 4) 	<p>3. Length of stay in prior living situation? For Transitional & Permanent Housing Situations:</p> <ul style="list-style-type: none"> <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 <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

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4. On the night before your current living situation did you stay on the streets; Emergency Shelter (ES), or Safe Haven (SH)?	<input type="checkbox"/> Yes(Continue to questions 5-7) <input type="checkbox"/> No (Proceed to Wellness Assessment) <input type="checkbox"/> Client Doesn't Know (Proceed to Wellness Assessment) <input type="checkbox"/> Client Refused (Proceed to Wellness Assessment)
5. What approximate date did you start living on the streets, emergency shelter, or safe haven? (Approximate date homelessness started) _____ / _____ / _____	
6. How many times have you been on the streets, 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 or more times <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
7. Total number of months homeless on the streets, in ES, or SH in the past three years?	<input type="checkbox"/> One Month (this time is the first month) <input type="checkbox"/> 2-12 (____ months) <input type="checkbox"/> More than 12 <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Wellness Assessment	
Health Insurance	<input type="checkbox"/> Yes (Enter Source (s) Below) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
<input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> MEDICAID <input type="checkbox"/> State Children's Health Insurance(SCHIP)	<input type="checkbox"/> VA Medical Services <input type="checkbox"/> Employer Provided Health Insurance <input type="checkbox"/> Health Insurance obtained through COBRA <input type="checkbox"/> State Funded Insurance Adults (Medi-Cal) <input type="checkbox"/> Combined Children's Health Insurance/Medicaid Program <input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Other (Specify): _____
Connection with SOAR (Is the client connected with BHRS SSI/SSDI staff, PATH O/R staff or other SOAR staff)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Alcohol Abuse	<input type="checkbox"/> Yes (Answer Questions Below) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
1. Expected to be of long-continued and indefinite duration and substantially impairs one's ability to live independently?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
2. Documentation of disability and severity on file? (Staff Answer)	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. How confirmed? PATH ONLY (Staff Answer)	<input type="checkbox"/> Unconfirmed; presumptive or self-report <input type="checkbox"/> Confirmed by prior evaluation or clinical records (ie Cerner) <input type="checkbox"/> Confirmed through assessment and clinical evaluation
Chronic Health Condition	<input type="checkbox"/> Yes (Answer Questions Below) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
1. Expected to be of long-continued and indefinite duration and substantially impairs one's ability to live independently?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Development Disability	<input type="checkbox"/> Yes (Answer Questions Below) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
1. Expected to be of long-continued and indefinite duration and substantially impairs one's ability to live independently?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Drug Abuse	<input type="checkbox"/> Yes (Answer Questions Below) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
1. Expected to be of long-continued and indefinite duration and substantially impairs one's ability to live independently?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
2. Documentation of disability and severity on file? (Staff Answer)	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. How confirmed? PATH ONLY (Staff Answer)	<input type="checkbox"/> Unconfirmed; presumptive or self-report <input type="checkbox"/> Confirmed by prior evaluation or clinical records (ie Cerner) <input type="checkbox"/> Confirmed through assessment and clinical evaluation
HIV/AIDS	<input type="checkbox"/> Yes (Answer Questions Below) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
1. Expected to be of long-continued and indefinite duration and substantially impairs one's ability to live independently?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Mental Health	<input type="checkbox"/> Yes (Answer Questions Below) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
1. Expected to be of long-continued and indefinite duration and substantially impairs one's ability to live independently?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
2. Documentation of disability and severity on file? (Staff Answer)	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. How confirmed? PATH ONLY (Staff Answer)	<input type="checkbox"/> Unconfirmed; presumptive or self-report <input type="checkbox"/> Confirmed by prior evaluation or clinical records (ie Cerner) <input type="checkbox"/> Confirmed through assessment and clinical evaluation

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4. Serious mental illness (SMI) and if SMI, how confirmed? PATH ONLY (Staff Answer)

- No Unconfirmed; presumptive or self-report
 Confirmed by prior evaluation or clinical records (ie Cerner) Confirmed through assessment and clinical evaluation

Physical Disability Yes (Answer Questions Below) No Client Doesn't Know Client Refused

1. Expected to be of long-continued and indefinite duration and substantially impairs one's ability to live independently?

- Yes No Client Doesn't Know Client Refused

Disabling Condition – If "Yes" to "Expected to be..." for any of the above barriers then this must be answered "Yes."

- Yes No Client Doesn't Know Client Refused

Financial Assessment - Check all that apply and enter amount

Income Source (Check all that apply)	Stated Income (Monthly)	Non-Cash Resources (Check all that apply)	Stated Amount (Monthly)
<input type="checkbox"/> Yes (Check all sources below that apply) <input type="checkbox"/> No (Ends this section) <input type="checkbox"/> Client Doesn't Know (Ends this section) <input type="checkbox"/> Client Refused (Ends this section)		<input type="checkbox"/> Yes (Check all sources below that apply) <input type="checkbox"/> No (Ends this section) <input type="checkbox"/> Client Doesn't Know (Ends this section) <input type="checkbox"/> Client Refused (Ends this section)	
<input type="checkbox"/> Earned Income (employment wages / cash)	\$	<input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	\$
<input type="checkbox"/> Unemployment Insurance	\$	<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP)	\$
<input type="checkbox"/> Supplemental Security Income (SSI)	\$	<input type="checkbox"/> CalWorks Child Care/TANF Child Care Services	\$
<input type="checkbox"/> Social Security Disability Income (SSDI)	\$	<input type="checkbox"/> CalWorks Transportation (TANF)	\$
<input type="checkbox"/> Private Disability Insurance	\$	<input type="checkbox"/> Other CalWorks-Funded Services (TANF)	\$
<input type="checkbox"/> Workers Compensation	\$	<input type="checkbox"/> Other Non-Cash Sources (Specify): _____	\$
<input type="checkbox"/> VA Service-Connected Disability Compensation	\$		
<input type="checkbox"/> VA Non-Service-Connected Disability Pension	\$		
<input type="checkbox"/> Pension or Retirement income from a job	\$		
<input type="checkbox"/> TANF	\$		
<input type="checkbox"/> General Assistance	\$		
<input type="checkbox"/> Retirement (Social Security)	\$		
<input type="checkbox"/> Child Support	\$		
<input type="checkbox"/> Alimony or other Spousal Support	\$		
<input type="checkbox"/> Other Income (Specify): _____	\$		

Contact

Date of Contact (E.G. 05/24/2010) _____ / _____ / _____ Contact Service: **570 PATH HMIS Intake Form**

Will the client be staying on the streets, in Emergency Shelter, or Safe Haven tonight?

Yes (I) No (J)
 Worker unable to determine (K)