

# HMIS Intake and Enrollment Form VA GPD

Client ID: \_\_\_\_\_

Staff Completing HMIS Form: \_\_\_\_\_

**Identification** - All fields required unless otherwise noted

<b>Completed HMIS Consent Form</b>	<b>No (Refused)</b>	<b>Signed</b>
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**First Name** \_\_\_\_\_ **Middle Name** \_\_\_\_\_

**Last Name** \_\_\_\_\_ **Suffix** \_\_\_\_\_

Name Data Quality: Did the client provide their full name?	Social Security Number (SSN)	Birth Date (DOB)
<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"/> Approximate or partial DOB reported <input type="checkbox"/> Full 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 Alaska 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	Relationship to Head of Household
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans Male (Female to Male) <input type="checkbox"/> Trans Female (Male to Female) <input type="checkbox"/> Non-Conforming (Not exclusively male or Female) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<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

Housing Move in Date(All PH - HOH ONLY)	Veteran (Have you ever served in the U.S. Military?)
____ / ____ / ____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
	<b>Disabling Condition</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Program Name:	
Case Manager:	
Program Start Date	

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Universal Data Assessment		
Client Location: <input type="checkbox"/> CA-510 – Turlock/ Modesto/ Stanislaus County CoC <input type="checkbox"/> Other: _____		
<b>Living Situation: (FOR ALL PROJECTS EXCEPT EMERGENCY SHELTER, SAFE HAVEN, AND STREET OUTREACH)</b>		
<p><b>1. What was type of residence you were living in immediately prior to project entry? (The night before)</b> <i>Literally Homeless Situations</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Place not meant for habitation</li> <li><input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter</li> <li><input type="checkbox"/> Safe Haven</li> <li><input type="checkbox"/> Interim Housing</li> </ul>	<p><b>2. Length of stay in prior living situation?</b> <i>For literally homeless situations:</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> One night or less</li> <li><input type="checkbox"/> Two to six nights</li> <li><input type="checkbox"/> One week or more, but less than one month</li> <li><input type="checkbox"/> One month or more, but less than 90 days</li> <li><input type="checkbox"/> 90 days or more, but less than one year</li> <li><input type="checkbox"/> One year or longer</li> <li><input type="checkbox"/> Client doesn't know</li> <li><input type="checkbox"/> Client refused</li> </ul>	<p><b>3. Did the Client stay less than... Not Applicable (Continue to questions 5-7)</b></p>
<p><b>1. What was the living Situation you were living in immediately prior to project entry?</b> <i>Institutional Situations</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Foster care home or foster care group home</li> <li><input type="checkbox"/> Hospital or other residential non-psychiatric medical facility</li> <li><input type="checkbox"/> Jail, prison or juvenile detention facility</li> <li><input type="checkbox"/> Long-term care facility or nursing home</li> <li><input type="checkbox"/> Psychiatric hospital or other psychiatric facility</li> <li><input type="checkbox"/> Substance abuse treatment facility or detox center</li> </ul>	<p><b>2. Did you stay less than... 90 Days</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes (Continue to questions 3-4)</li> <li><input type="checkbox"/> No (Enter Wellness Assessment)</li> </ul>	<p><b>3. Length of stay in prior living situation?</b> <i>For institutional situations:</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> One night or less</li> <li><input type="checkbox"/> Two to six nights</li> <li><input type="checkbox"/> One week or more, but less than one month</li> <li><input type="checkbox"/> One month or more, but less than 90 days</li> <li><input type="checkbox"/> 90 days or more, but less than one year</li> <li><input type="checkbox"/> One year or longer</li> <li><input type="checkbox"/> Client doesn't know</li> <li><input type="checkbox"/> Client refused</li> </ul>
<p><b>1. What was the living Situation you were living in immediately prior to project entry?</b> <i>Transitional &amp; Permanent Housing Situations</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher</li> <li><input type="checkbox"/> Owned by client, no ongoing housing subsidy</li> <li><input type="checkbox"/> Owned by client, with ongoing housing subsidy</li> <li><input type="checkbox"/> Permanent housing (Other than RRH) for formerly homeless persons</li> <li><input type="checkbox"/> Rental by client, no ongoing housing subsidy</li> <li><input type="checkbox"/> Rental by client, with VASH subsidy</li> <li><input type="checkbox"/> Rental by client, with GPD TIP subsidy</li> <li><input type="checkbox"/> Rental by client, with other ongoing housing subsidy (Including RRH)</li> <li><input type="checkbox"/> Residential project or halfway house with no homeless criteria</li> <li><input type="checkbox"/> Staying or living in a family member's room, apartment or house</li> <li><input type="checkbox"/> Staying or living in a friend's room, apartment or house</li> <li><input type="checkbox"/> Transitional housing for homeless persons (including homeless youth)</li> </ul>	<p><b>2. Did you stay less than... 7 Nights</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes (Continue to questions 3-4)</li> <li><input type="checkbox"/> No (Answer 3 then continue to Wellness Assessment)</li> </ul>	<p><b>3. Length of stay in prior living situation?</b> <i>Transitional &amp; Permanent Housing Situations</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> One night or less</li> <li><input type="checkbox"/> Two to six nights</li> <li><input type="checkbox"/> One week or more, but less than one month</li> <li><input type="checkbox"/> One month or more, but less than 90 days</li> <li><input type="checkbox"/> 90 days or more, but less than one year</li> <li><input type="checkbox"/> One year or longer</li> <li><input type="checkbox"/> Client doesn't know</li> <li><input type="checkbox"/> Client refused</li> </ul>

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4. On the night before your current housing situation did you stay on the street, Emergency Shelter, or Safe Haven	<input type="checkbox"/> Yes(Continue to questions 5-7) <input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> No (Continue with Wellness Assessment) <input type="checkbox"/> Client Refused
5. What approximate date did you start living on the streets, emergency shelter, or safe haven? (Approximate date homelessness started) _____ / _____ / _____		
6. How many times has the client been homeless on the streets, in shelters in the past 3 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. How many months, in total, have the client has been homeless on the street, in an emergency shelter, or Safe Haven over 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

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: \_\_\_\_\_

## Military Service History

<b>Date Entered Military Service</b>	_____ / _____ / _____	<b>Date Separated Military Service</b>	_____ / _____ / _____
<b>Branch of the Military</b>	<input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Navy <input type="checkbox"/> Marines	<input type="checkbox"/> Coast Guard <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
<b>Discharge Status</b>	<input type="checkbox"/> Honorable <input type="checkbox"/> General under Honorable Conditions <input type="checkbox"/> Under other than honorable conditions (OTH) <input type="checkbox"/> Bad conduct	<input type="checkbox"/> Dishonorable <input type="checkbox"/> Uncharacterized <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
<b>Theater of Operations</b>	<input type="checkbox"/> Yes (Answer questions below) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		
<b>Please Mark All that apply</b>	<input type="checkbox"/> World War II <input type="checkbox"/> Vietnam War <input type="checkbox"/> Persian Gulf Ware (Operation Desert Storm) <input type="checkbox"/> Afghanistan (Operation Enduring Freedom) <input type="checkbox"/> Iraq (Operation Iraqi Freedom) <input type="checkbox"/> Iraq (Operation New Dawn) <input type="checkbox"/> Other Peace-keeping Operations or Military Interventions (Such as Lebanon, Panama, Somalia, Bosnia, Kosovo) <input type="checkbox"/> Korean War		

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<b>Barriers:</b>		
	<b>Barrier Present</b>	<b>Condition is Indefinite</b>
Alcohol Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
Chronic Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
Development Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
Mental health	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
Physical Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
<b>Domestic Violence</b>		
<b>Is the client a domestic violence victim/survivor?</b>	<input type="checkbox"/> Yes (Answer questions below) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
<b>If yes, How long ago did you have this experience?</b>	<input type="checkbox"/> Within the past 3 months <input type="checkbox"/> 3 months to 6 months ago <input type="checkbox"/> 6 months to one year <input type="checkbox"/> One year ago or more <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
<b>If yes are you currently Fleeing?</b>	<input type="checkbox"/> Yes (Answer questions below) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	

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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 Amounts (Monthly)
<input type="checkbox"/> Yes (Check all Sources that Apply) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		<input type="checkbox"/> Yes (Check all Sources that Apply) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
<input type="checkbox"/> Earned Income ( <i>employment wages / cash</i> )	\$	<input type="checkbox"/> Special Supplemental nutritional Program Women and Children	\$
<input type="checkbox"/> Unemployment Insurance	\$	<input type="checkbox"/> Food Stamps (CalFresh) 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	\$
<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	\$		