Client ID: _____
Project Name: _____
Staff Name: _____

HMIS Intake and Enrollment Form

CoC/ESG/Private Funded

For persons entering HMIS project type: Emergency Shelter

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 prefers not to answer	☐Full SSN reported ☐Approximate or partial SSN reported ☐Client doesn't know ☐Client prefers not to answer	☐Approximate or partial DOB reported ☐Full DOB reported ☐Client doesn't know ☐Client prefers not to answer

Basic Demographics-*All fields required unless otherwise noted*

Race and Ethnicity *(Check all that apply)*

☐**American Indian, Alaska Native, or Indigenous** – A person who identifies with any of the original peoples of North, Central, and South America. Ex. include, but are not limited to, Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Tlingit, etc.

☐**Asian or Asian American** – A person who identifies with one or more nationalities or ethnic groups originating in East Asia, Southeast Asia, or the Indian subcontinent. Ex. include, but are not limited to, Chinese, Indian, Japanese, Korean, Pakistani, Vietnamese, or another representative nation/region.

☐**Black, African American, or African** – A person who identifies with one or more nationalities or ethnic groups originating in any of the Black racial groups of Africa, including Afro-Caribbean. Ex. include, but are not limited to, African American, Jamaican, Haitian, Nigerian, Ethiopian, and Somali.

☐**Hispanic/Latina/e/o** – A person who identifies with one or more nationalities or ethnic groups originating in Mexico, Puerto Rico, Cuba, Central and South American and other Spanish cultures. Ex. include but not limited to, Mexican or Mexican American, Puerto Rican, Cuban, Salvadorian, Dominican, and Columbian.

☐**Middle Eastern or North African** – A person who identifies with one or more nationalities or ethnic groups with origins in the Middle East and North Africa. Ex. include, but are not limited to, Lebanese, Iranian, Egyptian, Syrian, Moroccan, and Israeli.

☐**Native Hawaiian or Pacific Islander** – A person who identifies with one or more nationalities or ethnic groups originating in Hawaii, Guam, Samoa, or another Pacific Island.

☐**White** – A person who identifies with one or more nationalities or ethnic groups originating in Europe. Ex. include, but are not limited to, German, Irish, Polish, English, French, and Norwegian.

☐**Client doesn't know**

☐**Client prefers not to answer**

Additional Race and Ethnicity Detail: _____

Gender *(Check all that apply)* **Client authorizes update in HMIS if gender is different?** ☐Yes ☐No

☐**Woman** (Girl if child) - Client identifies as a woman, or girl in the case of a child under the age of 18

☐**Man** (Boy if child) - Client identifies as a man, or boy in the case of a child under the age of 18

☐**Culturally Specific Identity** (e.g. Two Spirit) - Client identifies with an identity that is exclusive to a particular culture. For example, Two-Spirit refers to a Native North American gender identity

☐**Transgender** - Client identifies with a transgender history, experience, or identity

☐**Non-binary** – Client does not identify exclusively as a man or a woman

☐**Questioning** - Client who may be unsure, may be exploring, or may not relate to or identify with a gender identity at this time. Note that 'Client does not know' is different from 'Questioning'. 'Questioning' is about exploring one's gender identity'. 'Client doesn't know' should only be selected when a client does not know their gender from the options available.

☐**Different Identity** *(Please specify)*: _____

☐**Client doesn't know**

☐**Client prefers not to answer**

Veteran Status *(Have you ever served in the U.S. Military?)*

☐Yes ☐No ☐Client does not know ☐Client prefers not to answer

Mailing Address and Contact Information *(Includes, not limited to, service organizations, access centers, emergency shelter, transitional housing, client residence)*

Address: _____

City, State, Zip Code: _____

Email: _____

Main Phone: _____

Message Phone: _____

Name of Head of Household: _____

Relationship to Head of Household

☐Self ☐Son ☐Daughter ☐Dependent child ☐Spouse ☐Other Family Member
☐Other Non-Family Member

Project Start Date: ____/____/_____

Universal Data Assessment

Disabling Condition

☐Yes ☐No ☐Client does not know ☐Client prefers not to answer

Living Situation: *Identify the type of residence and length of stay at that residence just prior to program admission*

1. What was the situation you were living in immediately prior to project entry? (*The night before)*

Literally Homeless	Institutional Situations	Temporary Housing	Permanent Housing
☐Place not meant for habitation: ☐**Car/ Truck/Van** ☐ **RV** ☐**Other** ☐Emergency Shelter, including hotel or motel paid for with emergency shelter voucher or Host Home shelter ☐Safe Haven	☐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	☐Transitional Housing for homeless persons (including homeless youth) ☐Residential project or halfway house with now homeless criteria ☐Hotel or motel paid for without emergency shelter voucher ☐Host Home (non-crisis) ☐Staying or living in a family member's room, apartment or house ☐Staying or living in a friend's room, apartment, or house	☐Rental by client, with no ongoing housing subsidy ☐Rental by client, with other ongoing housing subsidy **Subsidy Type:** ☐GPD TIP housing subsidy ☐VASH housing subsidy ☐RRH or equivalent subsidy ☐HCV voucher (tenant or project based) (not dedicated) ☐Public Housing Unit ☐Rental by client, with other ongoing housing subsidy ☐Emergency Housing Voucher ☐Family Unification Program Voucher (FUP) ☐Foster Youth to Independence Initiative (FYI) ☐Permanent Supportive Housing ☐Other permanent housing dedicated for formerly homeless persons ☐Owned by client, with ongoing housing subsidy ☐Owned by client, no ongoing Subsidy

☐Client doesn't know
☐Client prefers not to answer

2. 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 prefers not to answer

3. Approximate date this episode of homelessness started: ____/____/_____

4. Regardless of where they stayed last night, number of times client has been on the streets, 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 prefers not to answer

5. 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 (____ months)
☐More than 12 months ☐Client doesn't know
☐Client prefers not to answer

Health Insurance

☐Yes ☐No ☐Client does not know ☐Client prefers not to answer

Health Insurance Sources *(Check all that apply)*

☐Private Pay Health Insurance ☐Medicare
☐MEDICAID ☐Health Net (Medi-Cal)-Adults
☐Health Net (Medi-Cal)-Children ☐Health Plan of San Joaquin (Medi-Cal)-Adults
☐Health Plan of San Joaquin (Medi-Cal)-Children ☐State Children's Health Insurance (Medi-Cal)
☐Veteran's Health Administration (VHA) ☐Employer Provided Health Insurance
☐Health Insurance obtained through COBRA ☐State Funded Insurance for Adults (Medi-Cal)
☐Indian Health Services Program (IHS) ☐Other: _____

Barriers *(Check all that apply)*

Is the barrier expected to be long-continued or of indefinite duration? Does it substantially impede the client's availability to live independently; and could be improved by the provision of suitable housing?

	Barrier Present	**Condition is indefinite**
☐Alcohol Disorder	☐Yes ☐No ☐Doesn't know ☐ Client prefers not to answer	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer
☐Chronic Health Condition	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer
☐Developmental Disability	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer	
☐Drug Use Disorder	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer
☐HIV/AIDS	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer	
☐Mental Health Disorder	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer
☐Physical Disability	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer

Domestic Violence Survivor

Domestic Violence Experience?

☐Yes *(Answer questions below)* ☐No ☐Client doesn't know ☐Client prefers not to answer

When experience occurred?

☐Within the past 3 months ☐3 months to 6 months ago *(excluding 6 mos exactly)*
☐6 months to one year ago *(excluding 1 year exactly)* ☐One year ago or more
☐Client doesn't know ☐Client prefers not to answer

If yes, are you currently fleeing?

☐Yes ☐No ☐Client doesn't know ☐Client prefers not to answer

Financial Assessment	
Does client have any source of Income? *(If Yes, check all that apply)*	
☐Yes ☐No ☐Client does not know ☐Client prefers not to answer	
Income Source	**Monthly Amount**
☐Earned Income (employment wages/cash)	$
☐Unemployment Insurance	$
☐Supplemental Security Income (SSI)	$
☐Social Security Disability Insurance (SSDI)	$
☐Private Disability Insurance	$
☐Workers Compensation	$
☐VA Service-Connected Disability Compensation	$
☐VA Non-Service Connected Disability Pension	$
☐Pension of Retirement Income from a job	$
☐TANF (CalWorks)	$
☐General Assistance	$
☐Retirement (Social Security)	$
☐Child Support	$
☐Alimony	$
☐Other Income	$
Does client have any Non-Cash Benefits? *(If Yes, check all that apply)*	
☐Yes ☐No ☐Client does not know ☐Client prefers not to answer	
Non-Cash Benefits	**Monthly Amount**
☐Special Supplemental Nutrition Program for Woman, Infants, and Children	$
☐Food Stamps (CalFresh) SNAP	$
☐CalWorks Child Care/TANF Child Care Services	$
☐CalWorks Transportation (TANF)	$
☐Other CalWorks-Funded Services (TANF)	$
☐Other Sources	$

Translation Assistance Needed *(Head of Household Only)*				
☐Yes ☐No ☐Client does not know ☐Client prefers not to answer				
Preferred Language				
☐Arabic	☐Armenian	☐Cambodian	☐Cantonese	☐English
☐French	☐German	☐Hmong	☐Italian	☐Japanese
☐Korean	☐Mandarin	☐Mien	☐Portuguese	☐Russian
☐Samoan	☐Spanish	☐Tagalog	☐Thai	☐Vietnamese
☐Different Preferred Language				
If Different Preferred Language, *please specify:* _____				