

HMIS Intake and Enrollment Form

CoC/ESG/State & Private Funded

Client ID: _____

Project Name: _____

Staff Name: _____

For persons entering HMIS project type: **Transitional Housing, any type of Permanent Housing/RRH, Services Only, Homeless Prevention, Day Center** Also for persons entering CES Enrollment (reminder to collect the VI-SPDAT & Self-Sufficiency)

Returning Clients: Where did you go/stay when you left the last time you were here?

Identification-All fields required unless otherwise noted

First Name: _____ Middle Name: _____

Last Name: _____ Suffix: _____

Name Data Quality

Did the client provide their full name?

- Full Name Reported Partial, street name, or code name reported
 Client doesn't know Client prefers not to answer

Social Security Number (SSN): _____ - _____ - _____

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

Birth Date (DOB): ____/____/____

- 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 Asian or Asian American
 Black, African American, or African Hispanic/Latina/o
 Middle Eastern or North African Native Hawaiian or Pacific Islander
 White
 Client doesn't know
 Client prefers not to answer

Sex

- Female
 Male
 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: ____/____/____

Housing Move-In Date (All Permanent Housing Components) HOH Only
 ____/____/____

Universal Data Assessment	
Disabling Condition	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	
Living Situation: <i>Identify the type of residence and length of stay at that residence just prior to program admission</i>	
1. What was the situation you were living in immediately prior to project entry? (<i>The night before</i>)	
Literally Homeless	
<input type="checkbox"/> Place not meant for habitation: <input type="checkbox"/> Car/ Truck/Van <input type="checkbox"/> RV <input type="checkbox"/> Other <input type="checkbox"/> Emergency Shelter, including hotel or motel paid for with emergency shelter voucher or Host Home shelter <input type="checkbox"/> Safe Haven	
<i>*If selection made, continue to questions 2, 3-5</i>	
Institutional Situations	
<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	
<i>*If selection made, continue to question 1a</i>	
Temporary Housing	
<input type="checkbox"/> Transitional Housing for homeless persons (including homeless youth) <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"/> Host Home (non-crisis) <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	
<i>*If selection made, continue to question 1b</i>	
Permanent Housing	
<input type="checkbox"/> Rental by client, with no ongoing housing subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy Subsidy Type: <input type="checkbox"/> GPD TIP housing subsidy <input type="checkbox"/> VASH housing subsidy <input type="checkbox"/> RRH or equivalent subsidy <input type="checkbox"/> HCV voucher (tenant or project based) (not dedicated) <input type="checkbox"/> Public Housing Unit <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Emergency Housing Voucher <input type="checkbox"/> Family Unification Program Voucher (FUP) <input type="checkbox"/> Foster Youth to Independence Initiative (FYI) <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Other permanent housing dedicated for formerly homeless persons <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing subsidy	
<i>*If selection made, continue to question 1b</i>	
1a. Did you stay less than 90 days? (<i>*Pertains to Institutional Situation</i>)	
<input type="checkbox"/> Yes (<i>Continue to questions 2-2a</i>) <input type="checkbox"/> No (<i>Continue to question 2, then to Health Insurance</i>) <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	
1b. Did you stay less than 7 nights? (<i>*Pertains to Transitional & Permanent Housing Situations</i>)	
<input type="checkbox"/> Yes (<i>Continue to questions 2-2a</i>) <input type="checkbox"/> No (<i>Continue to question 2, then to Health Insurance</i>) <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	
2. Length of stay in prior living situation?	
<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 prefers not to answer	
2a. On the night before did you stay on the street, Emergency Shelter, or Save Haven?	
<input type="checkbox"/> Yes (<i>Continue to questions 3-5</i>) <input type="checkbox"/> No (<i>Continue to Health Insurance</i>) <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	
3. Approximate date <i>this episode</i> 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?		
<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 prefers not to answer	
5. 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="text" value=""/> months)	
<input type="checkbox"/> More than 12 months	<input type="checkbox"/> Client doesn't know	
<input type="checkbox"/> Client prefers not to answer		
Health Insurance		
<input type="checkbox"/> Yes (<i>Select source</i>)	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
Health Insurance Sources (<i>Check all that apply</i>)		
<input type="checkbox"/> Private Pay Health Insurance	<input type="checkbox"/> Medicare	
<input type="checkbox"/> MEDICAID	<input type="checkbox"/> Health Net (Medi-Cal)-Adults	
<input type="checkbox"/> Health Net (Medi-Cal)-Children	<input type="checkbox"/> State Kaiser (Medi-Cal)-Adults	
<input type="checkbox"/> State Kaiser (Medi-Cal)-Children	<input type="checkbox"/> Health Plan of San Joaquin (Medi-Cal)-Adults	
<input type="checkbox"/> Health Plan of San Joaquin (Medi-Cal)-Children	<input type="checkbox"/> State Children's Health Insurance (Medi-Cal)	
<input type="checkbox"/> Veteran's Health Administration (VHA)	<input type="checkbox"/> Employer Provided Health Insurance	
<input type="checkbox"/> Health Insurance obtained through COBRA	<input type="checkbox"/> State Funded Insurance for Adults (Medi-Cal)	
<input type="checkbox"/> Indian Health Services Program (IHS)	<input type="checkbox"/> Other: _____	
Barriers (<i>Check all that apply</i>)-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
<input type="checkbox"/> Alcohol Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Chronic Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Developmental Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Client prefers not to answer	
<input type="checkbox"/> Drug Use Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Client prefers not to answer	
<input type="checkbox"/> Mental Health Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Physical Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Client prefers not to answer
Domestic Violence Survivor		
Domestic Violence Experience?		
<input type="checkbox"/> Yes (<i>Answer questions below</i>)	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
When experience occurred?		
<input type="checkbox"/> Within the past 3 months	<input type="checkbox"/> 3 months to 6 months ago (<i>excluding 6 mos exactly</i>)	
<input type="checkbox"/> 6 months to one year ago (<i>excluding 1 year exactly</i>)	<input type="checkbox"/> One year ago or more	
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer	
If yes, are you currently fleeing?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer

Financial Assessment	
Does client have any source of income? (If Yes, check all that apply)	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client does not know <input type="checkbox"/> Client prefers not to answer	
Income Source	Monthly Amount
<input type="checkbox"/> Earned Income (employment wages/cash)	\$
<input type="checkbox"/> Unemployment Insurance	\$
<input type="checkbox"/> Supplemental Security Income (SSI)	\$
<input type="checkbox"/> Social Security Disability Insurance (SSDI)	\$
<input type="checkbox"/> Private Disability Insurance	\$
<input type="checkbox"/> Workers Compensation	\$
<input type="checkbox"/> VA Service-Connected Disability Compensation	\$
<input type="checkbox"/> VA Non-Service Connected Disability Pension	\$
<input type="checkbox"/> Pension of Retirement Income from a job	\$
<input type="checkbox"/> TANF (CalWorks)	\$
<input type="checkbox"/> General Assistance	\$
<input type="checkbox"/> Retirement (Social Security)	\$
<input type="checkbox"/> Child Support	\$
<input type="checkbox"/> Alimony	\$
<input type="checkbox"/> Other Income	\$
Does client have any Non-Cash Benefits? (If Yes, check all that apply)	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client does not know <input type="checkbox"/> Client prefers not to answer	
Non-Cash Benefits	Monthly Amount
<input type="checkbox"/> Special Supplemental Nutrition Program for Woman, Infants, and Children	\$
<input type="checkbox"/> Food Stamps (CalFresh) SNAP	\$
<input type="checkbox"/> CalWorks Child Care/TANF Child Care Services	\$
<input type="checkbox"/> CalWorks Transportation (TANF)	\$
<input type="checkbox"/> Other CalWorks-Funded Services (TANF)	\$
<input type="checkbox"/> Other Sources	\$
Moving On Assistance Provided: HUD Coc PSH	
Date of Service:	____/____/____
Moving On Assistance	
<input type="checkbox"/> Moving On Assistance-Financial Assistance for Moving On <input type="checkbox"/> Moving On Assistance-Housing referral/placement <input type="checkbox"/> Moving On Assistance-Non-Financial Assistance for Moving On <input type="checkbox"/> Moving On Assistance-Other (please specify) <input type="checkbox"/> Moving On Assistance-Subsidized Housing Application Assistance	

****FOR COORDINATED ENTRY****		<i>(Reminder to switch organization to Continuum of Care)</i>	
Project Start Date:		____/____/____	
Universal Data Assessment			
Disabling Condition			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer			
Self Sufficiency Matrix (Enter completed matrix into HMIS)			
Triage Assessment			
Assessment Location?		Assessment Type?	
<input type="checkbox"/> Stanislaus Community Care System		<input type="checkbox"/> Phone <input type="checkbox"/> Virtual <input type="checkbox"/> In Person	
What is household type?			
<input type="checkbox"/> Without Children <input type="checkbox"/> With children only <input type="checkbox"/> With children & adults <input type="checkbox"/> Unknown household type			
Information Date: ____/____/____		Triage Assessment Collection Point: <input type="checkbox"/> Entry <input type="checkbox"/> Update <input type="checkbox"/> Exit	
Current Living Situation			
1. Living Situation			
Literally Homeless			
<input type="checkbox"/> Place not meant for habitation: <ul style="list-style-type: none"> <input type="checkbox"/>Car/ Truck/Van <input type="checkbox"/>RV <input type="checkbox"/>Other <input type="checkbox"/> Emergency Shelter, including hotel or motel paid for with emergency shelter voucher or Host Home shelter <input type="checkbox"/> Safe Haven			
<i>*If selection made, continue to Contact Service</i>			
Institutional Situation			
<input type="checkbox"/> Foster Care Home or Foster Care Group Home <input type="checkbox"/> Jail, prison, or juvenile detention facility <input type="checkbox"/> Psychiatric hospital or other psychiatric facility		<input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Long-Term Care facility or nursing home <input type="checkbox"/> Substance abuse treatment facility or detox center	
<i>*If selection made, continue to question 2</i>			
Temporary Housing			
<input type="checkbox"/> Transitional Housing for homeless persons (including homeless youth) <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Staying or living in a family member's room apartment, or house		<input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Staying or living in a friend's room, apartment, or house	
<i>*If selection made, continue to question 2</i>			
Permanent Housing			
<input type="checkbox"/> Rental by client, with no ongoing housing subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy			
Subsidy Type:			
<input type="checkbox"/> GPD TIP housing subsidy <input type="checkbox"/> VASH housing subsidy <input type="checkbox"/> HCV voucher (tenant or project based) (not dedicated) <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Family Unification Program Voucher (FUP) <input type="checkbox"/> Permanent Supportive Housing		<input type="checkbox"/> RRH or equivalent subsidy <input type="checkbox"/> Public Housing Unit <input type="checkbox"/> Emergency Housing Voucher <input type="checkbox"/> Foster Youth to Independence Initiative (FYI) <input type="checkbox"/> Other permanent housing dedicated for formerly homeless persons	
<input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing subsidy			
<i>*If selection made, continue to question 2</i>			
<input type="checkbox"/> Other: _____ <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer			
2. Is client going to have to leave their current living situation within 14 days?			
<input type="checkbox"/> Yes <i>(Continue to questions 3-6)</i> <input type="checkbox"/> No <i>(Continue to Contact Service)</i> <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer			
3. Has a subsequent residence been identified?			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer			

4. Does client or family have resources or support networks to obtain other permanent housing?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	
5. Has the client had a lease or ownership interest in a permanent housing unit in the last 60 days?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	
6. Has the client moved 2 or more times in the last 60 days?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	
Contact Service Information	
Record Contact (Please list the service provided): _____	
Geolocation: <input type="checkbox"/> (Reminder to check box in HMIS)	
Additional Questions	
1a. Is there violence or conflict in the place you were staying last night?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	
1b. Is your health or safety at risk in the place you were staying last night?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	
***If yes to 1a AND 1b, continue to 1c	
1c. Do you have another place to go?	
<input type="checkbox"/> Yes (<i>continue to 1d</i>)	
<input type="checkbox"/> No, Special Intervention likely needed. (Comment): _____ (If DV may not be able to use HMIS)	
<input type="checkbox"/> Client doesn't know	
<input type="checkbox"/> Client prefers not to answer	
1d. How long could you potentially stay?	
<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 prefers not to answer
Prioritization Status:	<input type="checkbox"/> Placed on prioritization list <input type="checkbox"/> Not placed on prioritization list
Assessment-VI-SPDAT (Enter completed VI-SPDAT into HMIS)	