

HMIS Intake and Enrollment Form

Coordinated Entry

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

For persons entering HIMS project type: **Coordinated Entry**

Returning Clients: Where did you go/stay when you left the last time you were here? _____
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Identification-All fields required unless otherwise noted

First Name: _____	Middle Name: _____
Last Name: _____	Suffix: _____

Name Data Quality: Did the client provide their full name?

<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 prefers not to answer

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

<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 prefers not to answer

Birth Date (DOB): ____/____/____

<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 prefers not to answer

Basic Demographics-All fields required unless otherwise noted

Race and Ethnicity (Check all that apply)

<input type="checkbox"/> American Indian, Alaska Native, or Indigenous	<input type="checkbox"/> Asian or Asian American
<input type="checkbox"/> Black, African American, or African	<input type="checkbox"/> Hispanic/Latina/o
<input type="checkbox"/> Middle Eastern or North African	<input type="checkbox"/> Native Hawaiian or Pacific Islander
<input type="checkbox"/> White	
<input type="checkbox"/> Client doesn't know	
<input type="checkbox"/> Client prefers not to answer	

Sex

<input type="checkbox"/> Female
<input type="checkbox"/> Male
<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Client prefers not to answer

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

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client does not know	<input type="checkbox"/> Client prefers not to answer
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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

<input type="checkbox"/> Self	<input type="checkbox"/> Son	<input type="checkbox"/> Daughter	<input type="checkbox"/> Dependent child
<input type="checkbox"/> Spouse	<input type="checkbox"/> Other Family Member	<input type="checkbox"/> Other Non-Family Member	

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	
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 question 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>	
<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	
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 (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 (Check all that apply)	
<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: _____
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
Information Date: ____/____/____	Triage Assessment Collection Point: <input type="checkbox"/> Entry <input type="checkbox"/> Update <input type="checkbox"/> Exit

