

Client ID: _____

Project Name: _____

Staff Name: _____

HMIS Intake and Enrollment Form RHY

For persons entering HIMS project type: **RHY**

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

Pregnancy Yes * (Due Date: ____/____/____) No 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: _____

Relationship to Head of Household

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

Project Start Date: ____/____/____

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 <input type="checkbox"/> No <input type="checkbox"/> Client does not 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: _____	
BCP Status: (BCP Only)		
Date of Determination: ____/____/____		
Youth Eligible for RHY Services?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes (select options below)		
Is youth a runaway?		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer		
If No (reason why services are not funded by BCP Grant)		
<input type="checkbox"/> Out of age range		
<input type="checkbox"/> Ward of the State (Immediate Reunification)		
<input type="checkbox"/> Ward of the Criminal Justice System (Immediate Reunification)		
<input type="checkbox"/> 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
<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"/> 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? (<i>If Yes, check all that apply</i>)	
<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? (<i>If Yes, check all that apply</i>)	
<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	\$
Employment Assessment	
<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, Type of Employment	
<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Seasonal/Sporadic (including any day labor)	
If No, Why not employed?	
<input type="checkbox"/> Looking for work <input type="checkbox"/> Unable to work <input type="checkbox"/> Not looking for work	

Educational Assessment		
Last Grade Completed		
<input type="checkbox"/> No School Completed	<input type="checkbox"/> School Program does not have grade levels	<input type="checkbox"/> Nursery School to 4 th Grade
<input type="checkbox"/> 5 th Grade or 6 th Grade	<input type="checkbox"/> 7 th Grade or 8 th Grade	<input type="checkbox"/> 9 th Grade
<input type="checkbox"/> 10 th Grade	<input type="checkbox"/> 11 th Grade	<input type="checkbox"/> 12 th Grade, No Diploma
<input type="checkbox"/> High school diploma	<input type="checkbox"/> GED	<input type="checkbox"/> Post-Secondary
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer	
School Status		
<input type="checkbox"/> Attending school regularly	<input type="checkbox"/> Attending school irregularly	<input type="checkbox"/> Graduated from high school
<input type="checkbox"/> Obtained GED	<input type="checkbox"/> Dropped out	<input type="checkbox"/> Suspended
<input type="checkbox"/> Expelled	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
Health Assessment		
General Health Status		
<input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer		
Dental Health Status		
<input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer		
Mental Health Status		
<input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer		
Pregnancy Status		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer		
RHY Entry Assessment		
Referral Resources		
<input type="checkbox"/> Self-Referral <input type="checkbox"/> Individual/Parent/Guardian/Relative/Friend/Foster Parent/Other Individual		
<input type="checkbox"/> Outreach Project		
Number of times approached by outreach prior to the project: _____		
<input type="checkbox"/> Temporary Shelter	<input type="checkbox"/> Residential Shelter	<input type="checkbox"/> Hotline
<input type="checkbox"/> Juvenile Justice	<input type="checkbox"/> Law Enforcement/Police	<input type="checkbox"/> Mental Hospital
<input type="checkbox"/> Other Organization	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Child Welfare/CPS
		<input type="checkbox"/> School
		<input type="checkbox"/> Client prefers not to answer
Family Critical Issue		Status
Unemployment-Family Member		<input type="checkbox"/> Yes <input type="checkbox"/> No
Mental Health Disorder-Family Member		<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Disability-Family Member		<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcohol or Substance Use Disorder-Family Member		<input type="checkbox"/> Yes <input type="checkbox"/> No
Insufficient Income to support youth-Family Member		<input type="checkbox"/> Yes <input type="checkbox"/> No
Incarcerated Parent of Youth		<input type="checkbox"/> Yes <input type="checkbox"/> No
Formally a Ward of:		
System	Number of Years	If less than a year (<i>number of months</i>)
<input type="checkbox"/> Child Welfare/Foster Care Agency	<input type="checkbox"/> Less than one year <input type="checkbox"/> 1 to 2 years	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 3 to 5 years or more	
Juvenile Justice System	<input type="checkbox"/> Less than one year <input type="checkbox"/> 1 to 2 years	_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 3 to 5 years or more	