

MO-604 HMIS Intake form

Instructions: Please use this form to enter all information into CaseWorthy. Know that this form can be edited to fit your specific program needs.

Project Start Date: _____ **Move in Date:** _____ **Project Exit Date:** _____

Client ID number: _____ **Family ID number:** _____ **Relationship to HOH:** _____

First Name: _____ **Last Name:** _____

Middle Name: _____ **Suffix:** _____

Date of Birth: ____/____/____ **Deceased Date:** ____/____/____

Social Security Number: _____-_____-_____

Gender: Male Female Transgender Questioning A Gender that is not singularly (male/female) Client Doesn't Know

Citizenship: Eligible Non-Citizen Ineligible Non-Citizen U.S. Citizen Undocumented

Primary Language: Chinese Spanish English Bilingual- English/Spanish Russian Arabic

Race: White Black or African American Asian American Indian or Alaska Native Native Hawaiian/ Pacific Islander Client Doesn't Know Client Refused Data Not Collected

Ethnicity: Non-Hispanic/Non-Latin (a,o,x) Hispanic or Latin (a,o,x) Client Doesn't Know Client Refused Data Not Collected

Veteran Status: Yes No Client doesn't know Client refused Data Not Collected

Address: _____ **Apt. Number:** _____

Zip Code: _____ **City:** _____ **State:** _____ **County:** _____

Cell Phone: _____ **Home Phone:** _____

Work Phone: _____ **Email:** _____

Sharing: Client should be marked as shared. Not shared will cause all the client's information to not be visible to any org

UNIVERSAL ASSESSMENT

Client Location: (Will auto populate in HMIS) Continuum of Care Code: MO-604

Disabling Condition: No Yes Client Doesn't Know Client Refused Data Not Collected

Type of Residence (Residence Prior to Program entry): (This information is captured from the HOH only-Skip to Program Assessment)

Homeless Situation

Emergency Shelter including hotel-motel paid for with ES voucher or RHY Funded Host Home Shelter Place not meant for human habitation Safe Haven

Institutional Situation

Foster care 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 & Permanent Housing Situation

Hotel-motel paid without ES voucher Rented or owned by client, no ongoing housing subsidy Rented or owned ongoing housing subsidy
Permanent housing (other than RRH) Staying or living with family Transitional Housing for homeless person
Rental by client with GPD TID housing subsidy Residential project or halfway house with no Homeless criteria Host Home (non-crisis)
Rental by client with RRH or equivalent subsidy Rental by client with HCV Voucher Rental by client in a public housing unit
Client doesn't know Client refused Data Not Collected

If Type of Residence is a **HOMELESS SITUATION**, the questions below are required:

Length of Stay in the Prior Living Situation:

-
- One night or less
- Two days 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 refused
- Data Not Collected

Approximate Date Homelessness Started: ____/____/____

(Regardless of where they stayed last night): Number of Times the Client Has Been Homeless on the Streets, in ES, or SH in the Past Three Years Including Today:

Never in 3 Years One Time Two Times Three Times Four or More Times Client doesn't know Client refused Data Not Collected

Total Number of Months Homeless on the Streets, in ES, or SH in the Past Three Years: _____

If Type of Residence is an ***INSTITUTIONAL SITUATION***, the questions below are required:

Did you stay less than 90 days? Yes No

If Yes, **On the night before did you stay on the streets, ES or SH:** Yes No

Length of stay in the prior living situation:

90 days or more, but less than one year One year or longer Client Doesn't Know
 Client Refused Data Not Collected

If Type of Residence is a ***TRANSITIONAL or PERMANENT HOUSING SITUATION***, the question below is required:

Did you stay less than 7 nights? Yes No

If Yes, **On the night before did you stay on the streets, ES or SH:** Yes No

Length of Stay in the Prior Living Situation:

One night or less Two days to six nights

PROGRAM ASSESSMENT

Domestic Violence Survivor? Yes No Client doesn't know Client refused Data Not Collected

Non-cash benefit from any source? Yes No Client doesn't know Client refused

If yes, please list the Non-cash benefit source: _____

Covered by Health Insurance? Yes No Client doesn't know Client refused

General Health Status Excellent Very Good Good Fair Poor Client doesn't know Client refused

- The section below is required to be answered by CoC funded programs only

Client perceives their life has value and worth? strongly disagree Somewhat disagree Neither agree nor disagree Somewhat agree Strongly agree
 Client doesn't know Client refused Data Not Collected

Client perceives they have support from others who will listen to problems? strongly disagree Somewhat disagree Neither agree nor disagree
 Somewhat agree Strongly agree Client doesn't know Client refused Data Not Collected

Client perceives they have a tendency to bounce back after hard times? strongly disagree Somewhat disagree Neither agree nor disagree
 Somewhat agree Strongly agree Client doesn't know Client refused Data Not Collected

Client's frequency of feeling nervous, tense, worried, frustrated, or afraid? strongly disagree Somewhat disagree Neither agree nor disagree
 Somewhat agree Strongly agree Client doesn't know Client refused Data Not Collected

Disabling Conditions:

Substance Use Disorder: No Alcohol Drug Both Alcohol and Drug Client doesn't know Client refused Data Not Collected

If Yes, Is this expected to be of long-continued indefinite duration and substantially impairs ability to live independently?

Yes No Client doesn't know Client refused Data Not Collected

Mental Health Disorder: No Yes Client doesn't know Client refused Data Not Collected

If Yes, Is this expected to be of long-continued indefinite duration and substantially impairs ability to live independently?

Yes No Client doesn't know Client refused Data Not Collected

Developmental Disability: No Yes Client doesn't know Client refused Data Not Collected

Chronic Health Condition: No Yes Client doesn't know Client refused Data Not Collected

If Yes, Is this expected to be of long-continued indefinite duration and substantially impairs ability to live independently?

Yes No Client doesn't know Client refused Data Not Collected

HIV/AIDS: No Yes Client doesn't know Client refused Data Not Collected

Physical Disability: No Yes Client doesn't know Client refused Data Not Collected

If Yes, Is this expected to be of long-continued indefinite duration and substantially impairs ability to live independently?

Yes No Client doesn't know Client refused Data Not Collected

FINANCIAL ASSESSMENT

Income received from any source? Yes No Client doesn't know Client refused Data Not Collected

Income Type	Monthly Amount	Income Type	Monthly Amount
Unemployment Insurance	<input type="checkbox"/> N <input type="checkbox"/> Y \$	Retirement Income from Social Security	<input type="checkbox"/> N <input type="checkbox"/> Y \$
Earned/Employed Income	<input type="checkbox"/> N <input type="checkbox"/> Y \$	VA Non-Service-Connected Disability Pension	<input type="checkbox"/> N <input type="checkbox"/> Y \$
Supplemental Security Income (SSI)	<input type="checkbox"/> N <input type="checkbox"/> Y \$	Pension or Retirement income from a former job	<input type="checkbox"/> N <input type="checkbox"/> Y \$
Social Security Disability Insurance (SSDI)	<input type="checkbox"/> N <input type="checkbox"/> Y \$	Child Support	<input type="checkbox"/> N <input type="checkbox"/> Y \$
VA Service-Connected Disability Compensation	<input type="checkbox"/> N <input type="checkbox"/> Y \$	Alimony or other spousal support	<input type="checkbox"/> N <input type="checkbox"/> Y \$
Private Disability Insurance	<input type="checkbox"/> N <input type="checkbox"/> Y \$	Worker's Compensation	<input type="checkbox"/> N <input type="checkbox"/> Y \$

Temporary Assistance for Needy Families (TANF)	<input type="checkbox"/> N <input type="checkbox"/> Y \$	Other Source, Specify below:	<input type="checkbox"/> N <input type="checkbox"/> Y \$
General Assistance (GA)	<input type="checkbox"/> N <input type="checkbox"/> Y \$	Client Total Income	

HEALTH ASSESSMENT

Health Insurance from any source? Yes No Client doesn't know Client refused Data Not Collected

- | | |
|---|--|
| Medicaid | Medicare |
| State Children's Health Insurance Program | Veteran Administration (VA) Medical Services |
| Employer-Provided Health Insurance | Health Insurance obtained through COBRA |
| State Health Insurance for Adults | Private Pay Health Insurance |
| Indian Health Service Program | |
| Other Specify: _____ | |

Veteran Information

Branch of military: Air Force Army Marines Navy Coast Guard Client Doesn't Know Client Refused Other

Discharge status: Honorable General under Honorable Conditions Under Other than Honorable Conditions Bad Conduct
 Dishonorable Uncharacterized Don't Know Refused

Date Entered Service: _____/_____/_____ **Date Separated Service:** _____/_____/_____

Received Friendly or Hostile Fire: Yes No Client doesn't know Client refused Data Not Collected

HOPWA Information

Receiving Public HIV/AIDS Medical Assistance? No Yes Client doesn't know Client refused Data Not Collected

Receiving AIDS Drug Assistance Program (ADAP)? No Yes Client doesn't know Client refused Data Not Collected

Receiving Ryan White-funded Medical or Dental Assistance? No Yes Client doesn't know Client refused Data Not Collected

Has the client been prescribed anti-retroviral drugs? No Yes Client doesn't know Client refused Data Not Collected

T-cell (CD4) and Viral Load

T-Cell (cd4) Count Available? No Yes Client doesn't know Client refused Data Not

If Yes, T-CELL COUNT: _____

How was the T-Cell count information obtained? Medical Report Client Report Other

Viral Load Information Available? Not Available Available Undetectable Client doesn't know Client refused
 Closed Alternate Schedule Change in Capacity Data Not Collected

Runaway Homeless Youth

Assessment Date: ____/____/____

Interval: _____

HUD RHY ASSESSMENT

Referral Source:

Self-Referral	Parent/Guardian/Relative/Friend/Foster Parents/Other Individual	Outreach Project		
Temporary Shelter	Residential Shelter	Hotline	Child Welfare/CPS	Juvenile Justice
Law Enforcement/Police	Mental Hospital	School	Other Organization	Client Doesn't Know
Client Refused	Data not Collected			

Date of Status Determination: ____/____/____

Runaway Youth: No Yes Client Doesn't Know Client Refused Data Not Collected

Youth Eligible for RHY Services: Yes No

School Status: Attending school regularly Attending school irregularly Graduated from high school Obtained GED
 Dropped out Suspended Expelled Client Doesn't Know Client Refused Data Not Collected

Dental Health Status: Excellent Very Good Good Fair Poor Client Doesn't Know Client Refused Data Not Collected

Mental Health Status: Excellent Very Good Good Fair Poor Client Doesn't Know Client Refused Data Not Collected

Formerly a Ward of Child Welfare/Foster Care Agency: No Yes Client Doesn't Know Client Refused Data Not Collected

Formerly a Ward of the Juvenile Justice System: No Yes Client Doesn't Know Client Refused Data Not Collected

Young Person's Critical Issues

Household Dynamics	Sexual Orientation/Gender Identity- Youth	Sexual Orientation/Gender Identity- Family
Housing Issues- Youth	Housing Issues- Family	School or Educational Issues - Youth
School or Education Issues- Family	Unemployment – Youth	Unemployment - Family
Mental Health Issues- Youth	Mental Health Issues- Family	Health Issues - Youth
Health Issues – Family	Physical Disability – Youth	Physical Disability – Family
Mental Disability- Youth	Mental Disability- Family	Abuse and Neglect- Youth
Abuse and Neglect- Family	Alcohol or other drug abuse - Youth	Alcohol or other drug abuse – Family
Insufficient Income to support youth- Family	Active Military Parent- Family	
One parent/legal guardian of youth incarcerated	Both parents/legal guardians of youth incarceration	
Only Parent/legal guardian of youth incarcerated		