

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: ___/___/___

Client ID: _____ Family ID: _____ Relationship to HoH: _____

Project Name (as it appears in CaseWorthy): _____

Client Record:

Name: _____
First Middle Last Suffix

Name Data Quality Full name reported Partial, nickname, or code name reported
 Client doesn't know Client prefers not to answer

Social Security Number: _____ - _____ - _____

Full SSN reported Partial SSN Client doesn't know Client prefers not to answer

Client Demographics

Date of Birth: ___/___/___

Full DOB Partial DOB Client doesn't know Client prefers not to answer

Race: American Indian, Alaska Native, or Indigenous Asian or Asian American Black, African American, or African American Hispanic/Latina/e/o
Select all that apply Middle Eastern or North African Native Hawaiian or Pacific Islander White Other (Please Specify): _____
 Client doesn't know Client prefers not to answer

Gender: Woman (Girl if child) Man (Boy, if child) Culturally specific identity (e.g., Two-Spirit) Transgender
Select all that apply Non-Binary Questioning Client doesn't know Client prefers not to answer
 Different identity (please specify): _____

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

Primary Language: _____

Translation Assistance Needed?

Yes No Client Doesn't know Client prefers not to answer

U.S. Veteran Status: Yes No Client doesn't know Client prefers not to answer

Address _____ Apt. _____

Zip Code _____ City _____ State _____ County _____

Cell Phone _____ Home Phone _____

Work Phone _____ Email _____

Note: Clients should always be marked as "Shared"

HUD Universal Assessment

Disabling Condition? Yes No Client doesn't know Client prefers not to answer

Zip Code of the Last Permanent Address Client Remembers: _____

Full or Partial Zip Code Reported Client doesn't know Client prefers not to answer

Prior Living Situation (Street Homeless Situations):

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

Prior Living Situation (Institutional Situations):

Foster care home or foster care group home Long-term care facility or nursing home
 Hospital or other residential non-psychiatric medical facility Psychiatric hospital or other psychiatric facility
 Jail, prison, or juvenile detention facility Substance abuse treatment facility or detox center

Prior Living Situation (Temporary and Permanent Housing Situations):

Transitional housing for homeless persons (including homeless youth) Residential project or halfway house with no homeless criteria
 Hotel or motel paid for without emergency shelter voucher Host Home (non-crisis)
 Staying or living in a friend's room, apartment, or house Staying or living in a family member's room, apartment, or house
 Rental by client, no ongoing housing subsidy Rental by client, with ongoing housing subsidy
 Owned by client, with ongoing housing subsidy Owned by client, no ongoing housing subsidy
 Client doesn't know Client prefers not to answer

If the previous answer included renting or owning with *ongoing housing subsidy*, please select from one of the following:

GPD TIP housing subsidy VASH housing subsidy
 RRH or equivalent subsidy Foster Youth to Independence Initiative (FYI)
 HCV voucher (tenant or project based) (not dedicated) Public housing unit
 Rental by client, with other ongoing housing subsidy Housing Stability Voucher
 Family Unification Program Voucher (FUP) Permanent Supportive Housing
 Other permanent housing dedicated for formerly homeless persons

Approximate date homelessness started: ____/____/____

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

(Regardless of where they stayed last night): Number of times client has been homeless on streets, in ES, or SH in the *past three years* including today:

Never One time Two times Three times
 Four or more times Client doesn't know Client prefers not to answer

Total # of months homeless on the street, in ES, or SH in the *past three years*: _____. (Note, if the answer is 12 or more you only need to record 13)

HUD Program Assessment

Domestic Violence Survivor? Yes No Client Doesn't know Client prefers not to answer

If yes, when did the experience occur? Within the past 3 months 3-6 months ago
 6-12 months ago More than a year ago
 Client doesn't know Client prefers not to answer

If yes, currently fleeing? Yes No Client Doesn't know Client prefers not to answer

Non-cash benefit from any sources?

Yes No Client Doesn't know Client prefers not to answer

Supplemental Nutrition Assistance Program (SNAP) (Previously known as Food Stamps) Yes No
 Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Yes No
 TANF Child Care services Yes No
 TANF transportation services Yes No
 Other TANF-funded services Yes No
 Other non-cash benefit (please specify): Yes No

Does the client have health insurance?

Yes No Client Doesn't know Client prefers not to answer

- Please note that this answer is connected to the HUD Health Insurance Assessment

General Health Status:

Excellent Very Good Good Fair Poor Client doesn't know Client prefers not to answer

Sexual Orientation: *Required for RHY and CoC PSH programs

Heterosexual Gay Lesbian Bisexual Questioning/Unsure
 Client doesn't know Client prefers not to answer Other (specify) _____

Disabling Conditions:

DK=Client doesn't know; PNA=Client prefers not to answer

Disability Type:

Disability Determination

- If yes, expected to be of long-continued and indefinite duration and substantially impairs ability to live independently

Alcohol Use Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNA
Both Alcohol and Drug Use Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNA
Chronic Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNA
Developmental Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNA	(not applicable)
Drug Use Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNA
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNA	(not applicable)
Mental Health Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNA
Physical Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNA

HUD Financial Assessment

Income received from any sources?

Yes No Client Doesn't know Client prefers not to answer

Unemployment Insurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
Earned/Employed Income	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
Supplemental Security Income (SSI)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
Social Security Disability Insurance (SSDI)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
VA Service-Connected Disability Compensation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
VA Non-Service-Connected Disability Pension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
Private Disability Insurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
Temporary Assistance for Needy Families (TANF)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
General Assistance (GA)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
Retirement Income from Social Security	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
Pension or Retirement Income from a former job	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
Child Support	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
Alimony or other spousal support	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
Workers' Compensation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
Other source (specify below):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____

Total Monthly Income: \$ _____

HUD Health Insurance Assessment

Health Insurance from any source?

Yes No Client Doesn't know Client prefers not to answer

<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare	<input type="checkbox"/> State Children's Health Insurance Program
<input type="checkbox"/> VA Medical Services	<input type="checkbox"/> Employer-Provided Health Insurance	<input type="checkbox"/> Health Insurance obtained through COBRA
<input type="checkbox"/> Private Pay Health Insurance	<input type="checkbox"/> State Health Insurance for Adults	<input type="checkbox"/> Indian Health Services Program
<input type="checkbox"/> Other (please specify):	_____	