



HMIS Data Collection Form – Anchorage Coordinated Entry

FOR USE BY ANCHORAGE COORDINATED ENTRY ACCESS POINTS THAT SERVE INDIVIDUALS AND TRANSITION AGED YOUTH

PROJECT START INFORMATION

ENTER DATA AS (EDA) PROJECT	PROJECT START DATE	CONSENT GIVEN FOR STATEWIDE DATA SHARING? <input type="checkbox"/> Yes (Use <i>shared</i> 500,000 ID in HMIS) <input type="checkbox"/> No (Use <i>unshared</i> record in HMIS)
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CLIENT HMIS RECORD IDENTIFIERS

FIRST NAME	MI	LAST NAME
ALIASES	SOCIAL SECURITY NUMBER <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	US MILITARY VETERAN <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer

CLIENT CONTACT INFORMATION

Client Phone Number
Email or Message Line
Secondary Contact
Secondary Contact Number
Social Media Contact(s) (e.g., "Twitter @myclientsname; Facebook: Client Name.")

FEDERAL REPORTING REQUIREMENTS

RELATIONSHIP TO HEAD OF HOUSEHOLD (HOH) <input type="checkbox"/> Self <input type="checkbox"/> HoH's child <input type="checkbox"/> HoH's other relation member <input type="checkbox"/> HoH's spouse or partner <input type="checkbox"/> Other: non-relation member <input type="checkbox"/> Unknown
ENROLLMENT COC <input type="checkbox"/> AK-500 Anchorage Continuum of Care <input type="checkbox"/> AK-501 Alaska Balance of State Continuum of Care

CLIENT DEMOGRAPHICS

DATE OF BIRTH <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Full DOB <input type="checkbox"/> Partial DOB
RACE AND ETHNICITY <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> American Indian, Alaska Native, or Indigenous <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Black, African American, or African <input type="checkbox"/> White <input type="checkbox"/> Hispanic/Latina/e/o <input type="checkbox"/> Additional (specify):
GENDER <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Woman (Girl, if child) <input type="checkbox"/> Non-Binary <input type="checkbox"/> Man (Boy, if child) <input type="checkbox"/> Questioning <input type="checkbox"/> Culturally Specific Identity (e.g., Two-Spirit) <input type="checkbox"/> Different Identity (specify): <input type="checkbox"/> Transgender
SEXUAL ORIENTATION (Heads of Household and Adults only) <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Heterosexual/Straight <input type="checkbox"/> Lesbian <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Aromantic <input type="checkbox"/> Pansexual <input type="checkbox"/> Gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Other/Additional (specify to the right) → <input type="checkbox"/> Asexual <input type="checkbox"/> Queer <input type="checkbox"/> Demisexual <input type="checkbox"/> Other (Ex: same gender-loving, stud)



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DISABLING CONDITION INFORMATION

DISABLING CONDITIONS?

Client doesn't know
 Client prefers not to answer

- Yes (If yes, select answer for each type below.)
- No (If no, answer No for all types in HMIS.)

DISABLING CONDITIONS

(HUD TABLE)

	Yes	No	Doesn't know	Prefers not to answer		Yes	No	Doesn't know	Prefers not to answer
Alcohol Use Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes , does it affect their ability to live independently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Both Alcohol and Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Health Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Drug Use Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Mental Health Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

AK DISABLING CONDITIONS

	Yes	No	Doesn't know	Prefers not to answer
Alzheimer's Disease and Related Dementias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Alcoholism or other substance use disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual or Developmental Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traumatic Brain Injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ALASKA NATIVE REGIONAL CORPORATION

PRIMARY REGIONAL CORPORATION

Client doesn't know
 Client prefers not to answer

- Not Affiliated
- Sealaska
- Doyon Limited
- Calista
- Bering Straits Native
- Ahtna
- 13th Regional
- Koniag
- Chugach Alaska
- Cook Inlet Regional
- Bristol Bay Native
- Aleut
- Arctic Slope Regional
- NANA Regional

SECONDARY REGIONAL CORPORATION, IF APPLICABLE:



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PRIOR LIVING SITUATION INFORMATION (Heads of Household and Adults only)

TYPE OF RESIDENCE: LIVING SITUATION IMMEDIATELY PRIOR TO PROJECT START		<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
Homeless Situation	<input type="checkbox"/> Place not meant for habitation (for example: car, park, abandoned building, bus station, airport, tent) <input type="checkbox"/> Emergency shelter (ES), including hotel or motel paid for with ES voucher, Host Home shelter	
Institutional Situation	<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 use treatment facility or detox center	
Temporary Housing Situation	<input type="checkbox"/> Transitional housing for homeless persons youth (including homeless youth) <input type="checkbox"/> Residential project/halfway house with no homeless criteria <input type="checkbox"/> Hotel/motel paid for without ES voucher <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Staying or living in friend's room, apartment, or house <input type="checkbox"/> Staying or living in family's room, apartment, or house	
Permanent Housing Situation	<input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with housing subsidy (specify to the right) → <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy	if Rental by client, with housing subsidy, specify only one: <input type="checkbox"/> GPD TIP <input type="checkbox"/> VASH <input type="checkbox"/> RRH or equivalent <input type="checkbox"/> Housing Choice (HCV) <input type="checkbox"/> Public housing <input type="checkbox"/> Other ongoing subsidy <input type="checkbox"/> Family Unification Program (FUP) <input type="checkbox"/> Foster Youth to Independence (FYI) <input type="checkbox"/> Permanent Supportive Housing (PSH) <input type="checkbox"/> Other PH dedicated to formerly homeless

LENGTH OF STAY IN LIVING SITUATION IMMEDIATELY PRIOR TO PROJECT START	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> One night or less <input type="checkbox"/> One week or more, but less than a month <input type="checkbox"/> 90 days or more, but less than one year <input type="checkbox"/> Two to six nights <input type="checkbox"/> One month or more, but less than 90 days <input type="checkbox"/> One year or longer	

IF THE CLIENT IS CURRENTLY EXPERIENCING HOMELESSNESS, ANSWER THE FOLLOWING.

APPROXIMATE DATE THIS CURRENT EPISODE OF HOMELESSNESS STARTED
____/____/____

IF THE CLIENT HAS EXPERIENCED HOMELESSNESS IN THE PAST THREE YEARS, ANSWER THE FOLLOWING.

NUMBER OF EPISODES OF HOMELESSNESS IN THE PAST THREE YEARS INCLUDING TODAY	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> 1 time <input type="checkbox"/> 2 times <input type="checkbox"/> 3 times <input type="checkbox"/> 4 or more times	

IF THE CLIENT HAS EXPERIENCED HOMELESSNESS IN THE PAST THREE YEARS, ANSWER THE FOLLOWING.

NUMBER OF MONTHS HOMELESS IN THE PAST THREE YEARS INCLUDING THIS MONTH	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> 1 month (1 st month in the past 3 years) <input type="checkbox"/> 6 months <input type="checkbox"/> 10 months <input type="checkbox"/> 2 months <input type="checkbox"/> 7 months <input type="checkbox"/> 11 months <input type="checkbox"/> 3 months <input type="checkbox"/> 8 months <input type="checkbox"/> 12 months <input type="checkbox"/> 4 months <input type="checkbox"/> 9 months <input type="checkbox"/> More than 12 months <input type="checkbox"/> 5 months	



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DV INFORMATION

DOMESTIC VIOLENCE VICTIM/SURVIVOR?			<input type="checkbox"/> Client doesn't know
			<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Yes (If yes, select answer for each question below.)			
<input type="checkbox"/> No			
<i>When did the last experience occur?</i>	<input type="checkbox"/> Within past 3 months	<input type="checkbox"/> 6 to 12 months ago	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> 3 to 6 months ago	<input type="checkbox"/> More than a year ago	<input type="checkbox"/> Client prefers not to answer
<i>Are you currently fleeing?</i>	<input type="checkbox"/> Yes		<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> No		<input type="checkbox"/> Client prefers not to answer

INCOME INFORMATION

INCOME FROM ANY SOURCE?	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Yes (Specify Total Monthly Amount):	
<input type="checkbox"/> No	

COORDINATED ENTRY INFORMATION

COORDINATED ENTRY ASSESSMENT	
Assessment Location (Specify):	
Assessment Type:	<input type="checkbox"/> Phone <input type="checkbox"/> Virtual <input type="checkbox"/> In Person
Assessment Level:	<input type="checkbox"/> Crisis Needs <input type="checkbox"/> Housing Needs
Was client placed on the Prioritization List?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Total number of months experiencing homelessness the last 3 years? Specify up to 36 months:	

TRANSLATION ASSISTANCE INFORMATION

TRANSLATION ASSISTANCE NEEDED?				<input type="checkbox"/> Client doesn't know
				<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Yes (If yes, specify preferred language below.)				
<input type="checkbox"/> No				
<i>Preferred Language</i>	<input type="checkbox"/> English	<input type="checkbox"/> Central Alaskan Yup'ik / Yugtun	<input type="checkbox"/> Samoan	<input type="checkbox"/> Upper Kuskokwim
	<input type="checkbox"/> Spanish	<input type="checkbox"/> Gwich'in	<input type="checkbox"/> Tagalog	<input type="checkbox"/> Xaat Kil / Haida
	<input type="checkbox"/> Akuzipigestun / St. Lawrence Island Yupik (aka Siberian Yupik)	<input type="checkbox"/> Hawaiian	<input type="checkbox"/> Tanacross	<input type="checkbox"/> Yupik
	<input type="checkbox"/> Alutiiq	<input type="checkbox"/> Inupiatun / Inupiaq	<input type="checkbox"/> Tanana	<input type="checkbox"/> Different Preferred Language (Specify below.)
	<input type="checkbox"/> Atnakenaage' / Ahtna	<input type="checkbox"/> Koyukon	<input type="checkbox"/> Tlingit	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Russian	<input type="checkbox"/> Unangam Tunuu / Aleutian Aleut	<input type="checkbox"/> Client prefers not to answer	
<i>If Different Preferred Language, please specify:</i>				



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CONTACTS INFORMATION

Print additional copies of this page as needed.

CURRENT LIVING SITUATION

Record the date and location of each interaction with a client by recording their Current Living Situation.

Information Date (Date of Contact):

Where is the client currently staying? Select only one.

Homeless Situation Place not meant for habitation (for example: car, park, abandoned building, bus station, airport, tent) Emergency shelter (ES), including hotel or motel paid for with ES voucher, Host Home shelter

Institutional Situation Foster care home 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 use treatment facility or detox center

Temporary Housing 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

Permanent Housing Rental by client, no ongoing housing subsidy Rental by client, with housing subsidy (specify to the right) → Owned by client, with ongoing housing subsidy Owned by client, no ongoing housing subsidy

if Rental by client, with housing subsidy, specify only one:

GPD TIP GPD TIP
 VASH VASH
 RRH or equivalent RRH or equivalent
 Housing Choice (HCV) Housing Choice (HCV)
 Public housing Public housing

Other Other (specify):
 Worker unable to determine
 Client doesn't know
 Client prefers not to answer

Organization that verified client's living situation:

Worker who made contact with client:

Client location details (cross-streets, intersections, park):

If the client is currently in a non-homeless situation, will the client have to leave within 14 days?

Client doesn't know
 Client prefers not to answer

Yes (If yes, select answers below.)
 No

Yes No

Has a subsequent residence been identified? Yes No
Does client have resources or support networks to obtain other permanent housing? Yes No
Has client had a lease or ownership interest in a permanent housing unit in last 60 days? Yes No
Has client moved 2 or more times in the past 60 days? Yes No