**HMIS Intake – for Adults**Adult Information (one for each adult aged 18 years and older) Head of Household Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date Client Entered Project: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_** | | | | | | |
| **Social Security Number (SSN):** (write in SSN and check 1 data quality option): **\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_**  Full SSN Approx. or partial SSN Client doesn’t know Client prefers not to answer   Data not collected | | | | | | |
| **Client’s First and Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Full name Partial, street, or code name Client doesn’t know Client prefers not to answer   Data not collected | | | | | | |
| **Date of Birth (DOB): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**  Full DOB Approx. or partial DOB Client doesn’t know Client prefers not to answer   Data not collected | | | | | | |
| **Gender** (check all that apply):  Woman (Girl, if child) Man (Boy, if child) Culturally Specific Identity (e.g., Two-Spirit)  Transgender Non-Binary Questioning  Different Identity Client doesn’t know Client prefers not to answer Data not collected  **If Different Identity, please specify:** | | | | | | |
| **Race and Ethnicity** (check all that apply):  American Indian, Alaska Native, or Indigenous Asian or Asian American   Black, African American, or African Hispanic/Latina/e/o   Middle Eastern or North African Native Hawaiian or Pacific Islander   White Client doesn’t know   Client prefers not to answer Data not collected  **Additional Race and Ethnicity Detail** (if client would like to share additional info about their race or ethnicity, add here): | | | | | | |
| **U.S. Military Veteran:** Yes No Client doesn’t know Client prefers not to answer Data not collected | | | | | | |
| **Translation Assistance Needed:** Yes No Client doesn’t know Client prefers not to answer  Data not collected  *\*If yes, please specify client’s preferred language:* ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***  Different preferred language Client doesn’t know Client prefers not to answer   Data not collected  *\*If different preferred language selected, please specify:* | | | | | | |
| **Relationship to Head of Household**:  Self (Head of Household) Head of Household’s spouse or partner  Head of Household’s other relation member Other: non-relation member  Head of Household’s child Client doesn’t know  Client prefers not to answer Data not collected | | | | | | |
| **In which county is the client being housed or service being provided**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | |
| **Type of Residence on Night Before Project Entry (CHOOSE ONE OPTION FROM THE FOLLOWING THREE CATEGORIES):**  ***Homeless Situation***  Place not meant for habitation  Emergency shelter, including hotel or motel paid for with emergency shelter voucher Safe Haven  ***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 abuse treatment facility or detox center ***Transitional and Permanent Housing Situation***  Host Home (non-crisis)  Hotel or motel paid for without emergency shelter voucher  Owned by client, no ongoing housing subsidy  Owned by client, with ongoing housing subsidy  Rental by client, no ongoing housing subsidy  Rental by client, with ongoing housing subsidy  Residential project or halfway house with no homeless criteria  Staying or living in a family member's room, apartment, or house  Staying or living in a friend's room, apartment, or house  Transitional housing for homeless persons (including homeless youth)  Client doesn’t know  Client prefers not to answer  Data not collected | | | | | | |
| **Length of Stay in Prior Living Situation:**  One night or less Client doesn’t know  Two to six nights Client prefers not to answer  One week or more, but less than one month Data not collected  One month or more, but less than 90 days  90 days or more, but less than one year  One year or longer  **Approximate date this episode of homelessness started: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**  (homelessness = in shelter or on street)  **Regardless of where they stayed last night—number of times the client has been on the streets, in Emergency Shelter, or Safe Haven in the past three years (counting current stay):**  Never in 3 years One Time Two Times Three Times  Four or more times Client doesn’t know Client prefers not to answer Data not collected  **Total number of months the client has been homeless on the street, in Emergency Shelter, or Safe Haven in the past three years:**  1 month (this time is the first month) 2 months 3 months 4 months 5 months 6 months  7 months 8 months 9 months 10 months 11 months 12 months  More than 12 months (please specify): **\_\_\_\_\_\_\_\_\_\_\_\_** Client doesn’t know  Client prefers not to answer Data not collected | | | | | | |
| ***Disabling Condition:***  Does the client have a disabling condition? Yes No Client doesn’t know Client prefers not to answer  Data not collected | | | | | | |
| Circle below for each disability type: Y=Yes N=No DK=Doesn’t know PN=Prefers not to answer NC=Not collected | | | | | | |
| **Disability Type** | | | **Disability Determination**  **(Has disability)** | | **IF YES:** | Expected to be of long continued and indefinite duration and substantially impairs ability to live independently and of such a nature that such ability could be improved by more suitable housing conditions. |
| Physical Disability | | | Y N DK PN NC | | Y N DK PN NC |
| Developmental Disability | | | Y N DK PN NC | | N/A |
| Chronic Health Condition | | | Y N DK PN NC | | Y N DK PN NC |
| HIV/AIDS | | | Y N DK PN NC | | N/A |
| Mental Health Disorder | | | Y N DK PN NC | | Y N DK PN NC |
| Alcohol Use Disorder | | | Y N DK PN NC | | Y N DK PN NC |
| Drug Use Disorder | | | Y N DK PN NC | | Y N DK PN NC |
| Both Alcohol & Drug Use Disorder | | | Y N DK PN NC | | Y N DK PN NC |
| **Survivor of Domestic Violence:** Yes No Client doesn’t know Client prefers not to answer  Data not collected  *\*If yes, when experience occurred:*  Within the past three months Three to six months ago Six months to one year ago  One year ago, or more Client doesn’t know Client prefers not to answer   Data not collected  *\*If yes, are you currently fleeing:* Yes No Client doesn’t know Client prefers not to answer Data not collected | | | | | | |
| **Formerly a Ward of Child Welfare or Foster Care Agency:**  Yes No Client doesn’t know Client prefers not to answer Data not collected  *\*If yes, age you left system:* | | | | | | |
| **Previously in Kinship Care or Out of Home Care**:  Yes No Client doesn’t know Client prefers not to answer Data not collected  *\*If yes, age you left system:* | | | | | | |
| ***Monthly Income and Sources:***  Does the client have income from any source? Yes No Client doesn’t know Client prefers not to answer  Data not collected | | | | | | |
| **Yes** (Check box) | | **Monthly Amount** | | **Monthly Income Source** | | |
|  | | $ | | Alimony or Other Spousal Support | | |
|  | | $ | | Child Support | | |
|  | | $ | | Earned Income | | |
|  | | $ | | General Assistance (GA) | | |
|  | | $ | | Pension or Retirement Income from a Former Job | | |
|  | | $ | | Private Disability Insurance | | |
|  | | $ | | Retirement Income from Social Security | | |
|  | | $ | | Social Security Disability Income (SSDI) | | |
|  | | $ | | Supplemental Security Income (SSI) | | |
|  | | $ | | Temporary Assistance for Needy Families (TANF) | | |
|  | | $ | | Unemployment Insurance | | |
|  | | $ | | VA Non-Service-Connected Disability Pension | | |
|  | | $ | | VA Service-Connected Disability Compensation | | |
|  | | $ | | Worker’s Compensation | | |
|  | | $ | | Other Income Source (please specify): | | |
| ***Non-Cash Benefits***  Does the client have non-cash benefits from any source? Yes No Client doesn’t know  Client prefers to not answer Data not collected | | | | | | |
| **Yes** (Check box) | | **Non-Cash Benefits Type** | | | | |
|  | | Supplemental Nutrition Assistance Program (SNAP) (food stamps) | | | | |
|  | | Special Supplemental Nutrition for Women, Infants, and Children (WIC) | | | | |
|  | | TANF Childcare Services | | | | |
|  | | TANF Transportation Services | | | | |
|  | | Other TANF-Funded Services | | | | |
|  | | Other Non-Cash Benefit (please specify): | | | | |
| ***Health Insurance***  Is the client covered by health insurance? Yes No Client doesn’t know Client prefers not to answer  Data not collected | | | | | | |
| **Yes** (Check box) | **Health Insurance Type** | | | | | |
|  | MEDICAID | | | | | |
|  | MEDICARE | | | | | |
|  | State Children’s Health Insurance Program | | | | | |
|  | Veteran’s Health Administration (VHA) | | | | | |
|  | Employer-Provided Health Insurance | | | | | |
|  | Health Insurance Obtained Through COBRA | | | | | |
|  | Private Pay Health Insurance | | | | | |
|  | State Health Insurance for Adults | | | | | |
|  | Indian Health Services Program | | | | | |
|  | Other Health Insurance (please specify): | | | | | |