**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): |