SSVF Rapid Rehousing - AKHMIS Intake

Project Start Date (Use for Back Date Mode in AKHMIS): ____/____/_____ Staff Completing Intake: _____

Client Name: _____ Client Phone Number: (_____)_____-_____

Household Type:

☐ Couple with No Children ☐ Male Single Parent ☐ Grandparent(s) and Child ☐ Non-Custodial Caregiver(s)
☐ Female Single Parent ☐ Two Parent Family ☐ Foster Parent(s) ☐ Other: _____

For any answers below in which a client doesn't know or refuses to disclose information, please indicate **DK** (Doesn't Know) or **CR** (Client Refused).

Answer this section for each person in the household (complete additional data elements on the **Household Members** form and **Additional Adults** form). Please use additional forms for households with more than 6 people.

Client Name	SS#	Veteran?	Date of Birth	Race (see below)	Ethnicity (see below)	Gender (see below)	Relationship to Head of Household
		☐ Yes ☐ No	____/____/____				*Self (HoH)*
		☐ Yes ☐ No	____/____/____				
		☐ Yes ☐ No	____/____/____				
		☐ Yes ☐ No	____/____/____				
		☐ Yes ☐ No	____/____/____				
		☐ Yes ☐ No	____/____/____				

Race: **Indicate Primary Race (1)* & Secondary Race (2)

- American Indian / Alaska Native (*AI / AN*)
- Asian (*A*)
- Black / African American (*B / AA*)
- Native Hawaiian / Other Pacific Islander (*NH/PI*)
- White (*W*)
- Client doesn't know (*DK*)
- Client refused (*CR*)

Ethnicity:

- Non-Hispanic / Non-Latino (*N*)
- Hispanic / Latino (*H/L*)
- Client doesn't know (*DK*)
- Client refused (*CR*)

Gender:

- Female (*F*)
- Male (*M*)
- Trans Female - Male to Female (*MTF*)
- Trans Male - Female to Male (*FTM*)
- Gender Non-Conforming (*GNC*)
- Client doesn't know (*DK*)
- Client refused (*CR*)

Health Insurance (Check all that apply.)

Is the client covered by health insurance?
☐ Yes ☐ No
☐ Client doesn't know
☐ Client refused

☐ Medicaid
☐ Medicare
☐ State Children's Health Insurance Program
☐ Veteran's Administration Medical Services
☐ Employer-Provided Health Insurance
☐ Health Insurance obtained through COBRA
☐ Private Pay Health Insurance
☐ State Health Insurance for Adults
☐ Indian Health Services Program
☐ Other: _____

Disabilities (Check all that apply.)

Does the client have a disabling condition?
☐ Yes
☐ No
☐ Client doesn't know
☐ Client refused

Disability Type	Long-Continued and Indefinite Duration?
☐ **Alcohol Abuse**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
☐ **Both Alcohol & Drug Abuse**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
☐ **Chronic Health Condition**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
☐ **Developmental**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
☐ **Drug Abuse**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
☐ **HIV/AIDS**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
☐ **Mental Health Problem**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
☐ **Physical**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

Alaska Mental Health Trust (AMHT) Beneficiary (Select an answer for each disability type.)

Does the client have any of the following disabilities?

Alzheimer's Disease and Related Dementias	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Chronic Alcoholism or other Substance Use Disorder	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Intellectual or Developmental Disabilities	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Mental Illness	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Traumatic Brain Injuries	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

Primary Alaska Regional Corporation

☐ Not Affiliated

Secondary Alaska Regional Corporation (if applicable):

☐ Ahtna Corp.
☐ Aleut Corp.
☐ Arctic Slope Regional Corp.
☐ Bering Straits Native Corp.
☐ Bristol Bay Native Corp.
☐ Calista Corp.
☐ Chugach Alaska Corp.
☐ Cook Inlet Regional Corp.
☐ Doyon Limited Corp.
☐ Koniag Incorp.
☐ NANA Regional Corp.
☐ Sealaska
☐ 13th Regional Corp.
☐ Client doesn't know
☐ Client refused

For Permanent Housing Projects—including Rapid Rehousing Projects—*only*

If you are completing this for a project that is not a PH project and this data element is filled in on the Entry Assessment in HMIS, remove it.

Housing Move-In Date: _____/ _____/ _____

Client Name: _____ Client DOB: _____/ _____/ _____

"Where did you sleep last night?" (Select ***only one***, then complete the corresponding box below.)	☐Homeless Situation ☐Institutional Situation ☐Transitional or Permanent Housing Situation

☐ Homeless Situation

☐ Place not meant for habitation ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher

"How long have you been in this current homeless situation?"	☐ One night or less ☐ Two to six nights ☐ One week or more, but less than a month	☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer

<u>If Yes</u>, Approximate Date Homelessness started: _____/_____/_____

**The approximate date that the client's current episode of homelessness started.*

☐ Institutional Situation

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

"How long have you been in this institutional situation?"	☐ One night or less ☐ Two to six nights ☐ One week or more, but less than a month	☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer

*"If the stay was less than 90 days, on the night before entering the 'institutional situation,' were you **on the streets** or **in emergency shelter**?"*	☐ **Yes** ☐ **No**

<u>If Yes</u>, Approximate Date Homelessness started: _____/_____/_____

**The approximate date that the client's current episode of homelessness started.*

☐ Transitional & Permanent Housing Situation

☐ Hotel paid for without voucher ☐ Rental by client, GPD TIP subsidy
☐ Owned by client, no ongoing subsidy ☐ Rental by client, other subsidy including RRH
☐ Owned by client, ongoing subsidy ☐ Residential project, no homeless criteria
☐ Permanent housing for homeless persons- no RRH ☐ Staying or living with family
☐ Rental by client, no subsidy ☐ Staying or living with friends
☐ Rental by client, VASH subsidy ☐ Transitional housing for homeless persons

"How long have you been in this transitional or permanent housing situation?"	☐ One night or less ☐ Two to six nights ☐ One week or more, but less than a month	☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer

*"If the stay was less than 7 nights, on the night before entering the 'transitional or permanent housing situation,' were you **on the streets** or **in emergency shelter**?"*	☐ **Yes** ☐ **No**

<u>If Yes</u>, Approximate Date Homelessness started: _____/_____/_____

**The approximate date that the client's current episode of homelessness started.*

Living Situation *(Only complete if "Approximate Date Homelessness started" was answered above.)

"Regardless of where you stayed last night, <u>how many times</u> have you been **on the streets or **in emergency shelter** in the last 3 years?"*	☐ One time ☐ Two times ☐ Three times ☐ Four or more times
"<u>How many months</u> have you been **on the streets or in **emergency shelter** in the last 3 years?"*	☐ Fill in a number up to 12 months: _____ ☐ More than 12 months

"What is the primary reason that you are seeking assistance?"

☐ Illness/Injury
☐ Domestic Violence
☐ Hours of Work Cut
☐ House Repairs (Damaged/Destroyed)
☐ ATAP Delays/Sanction
☐ Death in Family
☐ Legal Issues
☐ Unemployed-Less than 60 Days
☐ Unemployed-More than 60 Days
☐ Nonpayment of Child Support
☐ Benefits Interrupted (i.e. SSI or VA)
☐ In Treatment
☐ Low Wages/Fixed Income
☐ Car Trouble/Accident
☐ Loss of Partner/Roommate
☐ Theft Victim
☐ Moved from w/in AK with Insufficient Funds
☐ Moved to AK with Insufficient Funds
☐ New Job/Paycheck Delay
☐ Mortgage Foreclosure
☐ Loss of Job
☐ Released from Medical Facility
☐ Released from Jail/Prison
☐ Living with Relative/Friend-Asked to Leave
☐ Substance Abuse
☐ Other (specify): _____

Client Name: _____ **Client DOB:** _____/ _____/ _____

Monthly Income (Select the specific sources and specify the monthly amount of each source.)

Does the client have a source of income?
☐ Yes ☐ No
☐ Client doesn't know
☐ Client refused

If yes, what is the total monthly income?

$_____

☐ Alimony/Other spousal support	$	☐ SSDI	$
☐ VA service connected disability compensation	$	☐ SSI	$
☐ VA non-service connected disability pension	$	☐ General assistance	$
☐ Worker's Compensation	$	☐ Unemployment insurance	$
☐ Retirement income from social security	$	☐ TANF	$
☐ Pension/Retirement income from another job	$	☐ Child support	$
☐ Private disability insurance	$	☐ Earned income	$

Non-Cash Benefits (Check all that apply.)

Does the client receive non-cash benefits?
☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

☐ TANF Child Care Services
☐ TANF Transportation Services
☐ Other TANF-Funded Services
☐ SNAP (Food Stamps)
☐ Special Supplemental Nutrition Program for WIC
☐ Other (specify): _____

Veteran Information

Year entered military service: _____/_____/_____

Year separated from military service: _____/_____/_____

Specific Theatre of Operations:
☐ World War II ☐ Korean War ☐ Vietnam War
☐ Persian Gulf War ☐ Afghanistan ☐ Iraq Freedom
☐ Iraq Dawn ☐ Other Peace-keeping Operations or Military Interventions

Branch of the Military:
☐ Army ☐ Air Force ☐ Navy ☐ Marines ☐ Coast Guard

Discharge Status:
☐ Honorable
☐ General under honorable conditions
☐ Under other than honorable conditions
☐ Bad Conduct
☐ Dishonorable
☐ Uncharacterized
☐ Client doesn't know
☐ Client refused

Percentage of AMI

This category is for extremely low income (ELI) participants to allow grantees the flexibility to provide extended temporary financial assistance for participants whose annual income does not exceed 30 percent of the area median income (AMI). This allows grantees to effectively serve participants with pronounced financial vulnerability and provide extended timeframes for the temporary financial assistance provided to them. This income determination is made only at participants' first entry into the SSVF program. *(VA SSVF Program Guide)*

☐ Less than 30% ☐ 30% to 50% ☐ Greater than 50%

Client's Residence / Last Permanent Address

Client's Street Address:	
Client's City:	
Client's State:	
Client's Zip Code:	
Address Data Quality:	☐ Full address ☐ Incomplete or estimated address ☐ Client doesn't know
Reason for Leaving this Residence:	☐ Building condemned ☐ Evicted ☐ Family / Friend Conflict ☐ Fire ☐ Moved to New Residence ☐ Other ☐ Overcrowding ☐ Unable to Pay Rent

VA Medical Center (VAMC) Station Number:

Connection with SOAR? (SOAR: SSI/SSDI Outreach Access & Recovery Program)

☐ Yes ☐ No ☐ Client doesn't know

Last Grade Completed:

☐ Less than Grade 5
☐ Grades 5-6
☐ Grades 7-8
☐ Grades 9-11
☐ Grade 12/High school diploma
☐ School does not have grades
☐ GED
☐ Some college
☐ Associate's degree
☐ Bachelor's degree
☐ Graduate degree
☐ Vocational certification