Mat-Su Valley AKHMIS Intake Form

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

Zip Code of Last Permanent Address: _____

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

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

Secondary Alaska Regional Corporation (if applicable): _____

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

Please note that if you are completing this for a project that is not a permanent housing project and this data element is filled in on the Entry Assessment in HMIS for this client, remove it on the Entry Assessment.

Housing Move-In Date: _____/ _____/ _____

"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
☐ Hospital or other residential 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

"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
☐ Owned by client, no ongoing subsidy
☐ Owned by client, ongoing subsidy
☐ Permanent housing for homeless persons- no RRH
☐ Rental by client, no subsidy
☐ Rental by client, VASH subsidy
☐ Rental by client, GPD TIP subsidy
☐ Rental by client, other subsidy including RRH
☐ Residential project, no homeless criteria
☐ Staying or living with family
☐ Staying or living with friends
☐ 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

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

"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): _____

Monthly Income (Select the specific sources and 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?

$_____

Source of Income	Recipient	Amount
☐ Alimony or other spousal support:		$
☐ VA service connected disability compensation:		$
☐ VA non-service connected disability pension:		$
☐ Worker's Compensation:		$
☐ Retirement income from social security:		$
☐ Pension or retirement income from another job:		$
☐ Private disability insurance:		$
☐ SSDI:		$
☐ SSI:		$
☐ General assistance:		$
☐ Unemployment insurance:		$
☐ TANF:		$
☐ Child support:		$
☐ 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): _____

Domestic Violence Victim / Survivor

"Are you a victim or survivor of domestic violence?"	☐ Yes	☐ No	☐ Client doesn't know	☐ Client refused
If yes, when did the last experience occur?	☐ Within the last 3 months	☐ 6-12 months ago	☐ 1+ years ago	☐ Client doesn't know ☐ Client refused
If yes, is the client currently fleeing the DV situation?	☐ Yes	☐ No	☐ Client doesn't know	☐ Client refused

Mat-Su Services

Service Provider: _____ **Provider Phone Number:** _____

Service Type	Rent Payment	Utilities, gas, etc.	Other (specify): _____
Amount	$	$	$

Mat-Su Specific Questions

"Have you or anyone in your household received funding from a Valley Partnership granting agency?"	**If Yes**, from which agency?	**If Yes**, what assistance did you receive?
☐ **Yes** ☐ **No**	☐ Alaska Family Svcs. ☐ Blood n Fire ☐ Daybreak ☐ Family Promise ☐ MYHouse ☐ Salvation Army ☐ Valley Charities	

By signing below, I am acknowledging that the information I have provided is accurate, and that providing false information may be grounds for denying services. I am also aware that this information may be shared with other grant partner agencies with the purpose of providing services to my household.

Client Signature: _____ Date: _____/_____/_____

Client Printed Name: _____