

HMIS Intake and Enrollment Form

Client Name / ID: _____

Identification (All fields required unless otherwise noted)

HMIS consent? No (refused) Signed Consent Form

First Name: _____ Middle Name (Optional): _____

Last Name: _____ Suffix (Optional): _____

Name Data Quality:		Physical Description (Optional):	Last Known Permanent Address:	
Did the client provide their full name?			Where have you last lived for 90 days or more? (Not including emergency shelters and transitional housing)	
<input type="checkbox"/> Full Name Reported <input type="checkbox"/> Partial, street name, or code name reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected			Address: _____	
			City: _____	
			County: _____	
Date of Birth:	SSN:		State: _____	
____/____/____	____-____-____		Zip: _____	
<input type="checkbox"/> Full DOB reported <input type="checkbox"/> Approximate or partial DOB reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	<input type="checkbox"/> Full SSN reported <input type="checkbox"/> Approximate or partial SSN reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected		Address Data Quality: <input type="checkbox"/> Full address reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Incomplete or estimated address reported <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	

Contact Information (Optional)

Phone Number	Phone Type	Contact Preference
Main: (____)____-____ x____ <input type="checkbox"/> Leave message	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Message Center	<input type="checkbox"/> Phone <input type="checkbox"/> Alternate Phone <input type="checkbox"/> Text <input type="checkbox"/> Email
Alternate: (____)____-____ x____ <input type="checkbox"/> Leave message	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Message Center	
Email: _____@_____	Notes	

Demographics (All fields required unless otherwise noted)

Housing Status:	Family Type:
<input type="checkbox"/> Category 1 - Homeless <input type="checkbox"/> Category 2 - At Imminent Risk of Losing Housing (within 14 days or less) <input type="checkbox"/> Category 3 - Homeless only under other Federal Statutes <input type="checkbox"/> Category 4 - Fleeing Domestic Violence <input type="checkbox"/> At Risk of Homelessness <input type="checkbox"/> Stably Housed	<input type="checkbox"/> Unaccompanied <input type="checkbox"/> Single Parent <input type="checkbox"/> Two Parents <input type="checkbox"/> Adults No children
	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected

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Relation (to Head of Household)	Gender:
<input type="checkbox"/> Self <input type="checkbox"/> Head of Household's Child <input type="checkbox"/> Head of Household's Spouse or Partner <input type="checkbox"/> Head of Household's other Relation Member <input type="checkbox"/> Other: Non-relation Member	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Other (Specify: _____)
	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected

Disabled? (Physical, Developmental, Mental Health, Chronic Health Condition, HIV/AIDS, and/or Substance Use Disorder.)	Veteran (Have you ever served in the U.S. Military?)	Education Level (What is the highest level of education you've completed?)
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	<input type="checkbox"/> No Schooling Completed <input type="checkbox"/> Nursery School to 4 th Grade <input type="checkbox"/> 5 th or 6 th Grade <input type="checkbox"/> 7 th or 8 th Grade <input type="checkbox"/> 9 th Grade <input type="checkbox"/> 10 th Grade <input type="checkbox"/> 11 th Grade
		<input type="checkbox"/> 12 th Grade, no diploma <input type="checkbox"/> High School Diploma <input type="checkbox"/> GED <input type="checkbox"/> Post-Secondary School <input type="checkbox"/> 4-year College Degree <input type="checkbox"/> Graduate School <input type="checkbox"/> Unknown

Ethnicity	Race (check all that apply)
<input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	<input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> White <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected

Income and Insurance (All fields required unless otherwise noted)

Income Source (Check all that apply)	Stated Income	Pay Interval					
		Weekly	Every Other Week	Twice A Month	Monthly	Quarterly	Yearly
<input type="checkbox"/> No financial resources	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Earned Income (<i>employment wages / cash</i>)	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Unemployment Insurance	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Supplemental Security Income (SSI)	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Social Security Disability Income (SSDI)	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> VA Service-Connected Disability Compensation	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> VA Non-Service-Connected Disability Pension	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Private Disability Insurance	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Workers Compensation	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Temporary Assistance for Needy Families (<i>CalWORKs</i>)	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> General Assistance (GA) (<i>General Relief (GR)</i>)	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Retirement Income from Social Security	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pension or retirement income from a former job	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Child Support	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Alimony or other spousal support	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other Source (Specify: _____)	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Client Doesn't Know							
<input type="checkbox"/> Client Refused							
<input type="checkbox"/> Data not Collected							

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Income Documentation (Optional):	Comments (Optional):
<input type="checkbox"/> GR Form <input type="checkbox"/> CalWORKS Forms <input type="checkbox"/> Pension Letter/Stub	
<input type="checkbox"/> Pay Stub <input type="checkbox"/> Unemployment Insurance Forms <input type="checkbox"/> Unemployment Forms	
<input type="checkbox"/> Utility Allowance <input type="checkbox"/> W-2 Forms <input type="checkbox"/> Self Declaration	
<input type="checkbox"/> Child Support Forms <input type="checkbox"/> SSDI Form <input type="checkbox"/> Employer Printout/Letter	
<input type="checkbox"/> Social Security Forms <input type="checkbox"/> Workmans Comp <input type="checkbox"/> VA Documentation	
<input type="checkbox"/> SSI Forms <input type="checkbox"/> Self Employment Docs	

Non-Cash Benefits (Check all that apply):			
<input type="checkbox"/> None	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data not Collected
<input type="checkbox"/> Food Stamps (CalFresh) Amount: _____	<input type="checkbox"/> CalWorks Child Care	<input type="checkbox"/> Temporary Rental Assistance	
<input type="checkbox"/> WIC	<input type="checkbox"/> CalWorks Transportation	<input type="checkbox"/> Section 8 or Rental Assistance	<input type="checkbox"/> Medically Needy Amount: _____
	<input type="checkbox"/> Other CalWorks-Funded Services	<input type="checkbox"/> Other _____	

Health Insurance (Check all that apply):			
<input type="checkbox"/> No Health Insurance	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data not Collected
<input type="checkbox"/> MEDICAID	<input type="checkbox"/> MEDICARE	<input type="checkbox"/> State Children's Health Ins.	<input type="checkbox"/> VA Medical Services
<input type="checkbox"/> Employer Provided Health Ins.	<input type="checkbox"/> COBRA Health Ins.	<input type="checkbox"/> Private Health Ins.	<input type="checkbox"/> MediCal

Client Note (Optional)

Client Note:	
Type: <input type="checkbox"/> Information <input type="checkbox"/> Alert	
Private Customer: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Note Date: ____/____/____	

Emergency Contact Information (Optional)

Contact Type	Phone Number	Phone Type	Email
Alternate Contact <i>(Who is the best person to get in touch with you?)</i> Relationship: _____ First Name: _____ Last Name: _____	() ____ - ____ x _____	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Message Center	
Emergency <i>(In case of an emergency, who should we alert?)</i> <input type="checkbox"/> Same as above Relationship: _____ First Name: _____ Last Name: _____	() ____ - ____ x _____	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Message Center	

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Program Entry (All fields required unless otherwise noted)

Program Name: _____

Program Entry Date: ____/____/____

Case Manager: _____

1. Where did you sleep last night?

- | | |
|--|---|
| <input type="checkbox"/> Emergency shelter | <input type="checkbox"/> Rental by client, with GPD TIP subsidy |
| <input type="checkbox"/> Foster care home or foster care group home | <input type="checkbox"/> Rental by client, with other (non-VASH) ongoing housing subsidy |
| <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility* | <input type="checkbox"/> Residential project or halfway house with no homeless criteria |
| <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher | <input type="checkbox"/> Safe Haven |
| <input type="checkbox"/> Jail, prison or juvenile detention facility* | <input type="checkbox"/> Staying or living in a family member's room, apartment, or house |
| <input type="checkbox"/> Long-term care facility or nursing home | <input type="checkbox"/> Staying or living in a friend's room, apartment or house |
| <input type="checkbox"/> Owned by client, no ongoing housing subsidy | <input type="checkbox"/> Substance abuse treatment facility or detox center* |
| <input type="checkbox"/> Owned by client, with ongoing housing subsidy | <input type="checkbox"/> Transitional housing for homeless persons |
| <input type="checkbox"/> Permanent housing for formerly homeless persons | <input type="checkbox"/> Other |
| <input type="checkbox"/> Place not meant for habitation | <input type="checkbox"/> Client Doesn't Know |
| <input type="checkbox"/> Psychiatric hospital or other psychiatric facility* | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Rental by client, no ongoing housing subsidy | <input type="checkbox"/> Data not Collected |
| <input type="checkbox"/> Rental by client, with VASH housing subsidy | |

1a. If "Other" prior residence was selected, please specify (Required only if question #1 was answered as "Other")

2. How long was your stay?

- | | | |
|---|---|--|
| <input type="checkbox"/> One day or less* | <input type="checkbox"/> One to three months* | <input type="checkbox"/> Client Doesn't Know |
| <input type="checkbox"/> Two days to one week* | <input type="checkbox"/> More than three months, but less than one year | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> More than one week, but less than one month* | <input type="checkbox"/> One year or longer | <input type="checkbox"/> Data not Collected |

3. Have you been continuously homeless for at least one year?

- | | | |
|------------------------------|--|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Data not Collected |
| <input type="checkbox"/> No | <input type="checkbox"/> Client Refused | |

4. How many times have you been homeless in the past three years?

- | | | |
|---|------------------------------------|--|
| <input type="checkbox"/> 0 (not homeless - Prevention only) | <input type="checkbox"/> 3 | <input type="checkbox"/> Client Doesn't Know |
| <input type="checkbox"/> 1 (homeless only this time) | <input type="checkbox"/> 4 or more | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> 2 | | <input type="checkbox"/> Data not Collected |

4a. Total number of months homeless in the past three years (Required only if question #4 was answered as "4 or more")

- | | | |
|----------------------------|-----------------------------|--|
| <input type="checkbox"/> 0 | <input type="checkbox"/> 6 | <input type="checkbox"/> 12 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 7 | <input type="checkbox"/> More than 12 months |
| <input type="checkbox"/> 2 | <input type="checkbox"/> 8 | <input type="checkbox"/> Client Doesn't Know |
| <input type="checkbox"/> 3 | <input type="checkbox"/> 9 | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> 4 | <input type="checkbox"/> 10 | <input type="checkbox"/> Data not Collected |
| <input type="checkbox"/> 5 | <input type="checkbox"/> 11 | |

5. Total number of months continuously homeless immediately prior to project entry

_____ Months

6. Status Documented

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

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HOMELESSNESS - Adults aged 18 and older and Head of Household < 18 years old, required questions are shaded

Question	Check One Answer	Comments
<p>7. Where were you sleeping prior to entering the institutional setting mentioned above (in question #1)?</p> <p>(Required if question #2 was answered as three months or less (*) AND question #1 was answered as one of the following (*):</p> <ul style="list-style-type: none"> -“Hospital or other residential non-psychiatric medical facility” -“Jail, prison or juvenile detention facility” -“Psychiatric hospital or other psychiatric facility” -“Substance abuse treatment facility or detox center” 	<input type="checkbox"/> Emergency shelter <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"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Jail, prison or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Permanent housing for formerly homeless persons <input type="checkbox"/> Place not meant for habitation <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Rental by client, with GPD TIP subsidy <input type="checkbox"/> Rental by client, with other (non-VASH) ongoing housing subsidy <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Safe Haven <input type="checkbox"/> Staying or living in a family member's room, apartment, or house <input type="checkbox"/> Staying or living in a friend's room, apartment or house <input type="checkbox"/> Substance abuse treatment facility or detox center <input type="checkbox"/> Transitional housing for homeless persons <input type="checkbox"/> Other <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	

WELLNESS – All clients, required questions are shaded

Question	Check One Answer	Comments
8. Have you been diagnosed with AIDS or have you tested positive for HIV?	<input type="checkbox"/> No <input type="checkbox"/> Yes**	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected
8a. Do you expect this to substantially impair your ability to live independently? (Required if question 8 is 'Yes')	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected
8b. Do you have documentation of the disability and severity on file? (Required if question 8 is 'Yes')	<input type="checkbox"/> No <input type="checkbox"/> Yes	
8c. Are you currently receiving services or treatment for this condition? (Required if question 8 is 'Yes')	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected
9. Do you have a chronic health condition?	<input type="checkbox"/> No <input type="checkbox"/> Yes**	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected
9a. Do you expect this to be of long-continued and indefinite duration AND substantially impair your ability to live independently? (Required if question 9 is 'Yes')	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected
9b. Do you have documentation of the disability and severity on file? (Required if question 9 is 'Yes')	<input type="checkbox"/> No <input type="checkbox"/> Yes	

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<p>9c. Are you currently receiving services or treatment for this condition? (Required if question 9 is 'Yes')</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
<p>10. Do you have a physical disability?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes**	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
<p>10a. Do you expect this to be of long-continued and indefinite duration AND substantially impair your ability to live independently? (Required if question 10 is 'Yes')</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
<p>10b. Do you have documentation of the disability and severity on file? (Required if question 10 is 'Yes')</p>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
<p>10c. Are you currently receiving services or treatment for this condition? (Required if question 10 is 'Yes')</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
<p>11. Do you <i>currently</i> have a drug or alcohol problem?</p>	<input type="checkbox"/> No <input type="checkbox"/> Alcohol** <input type="checkbox"/> Drug** <input type="checkbox"/> Both**	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
<p>11a. Do you expect this to be of long-continued and indefinite duration AND substantially impair your ability to live independently? (Required if question 11 is 'Alcohol', 'Drug', or 'Both')</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
<p>11b. Do you have documentation of the disability and severity on file? (Required if question 11 is 'Alcohol', 'Drug', or 'Both')</p>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
<p>11c. Are you currently receiving services or treatment for this condition? (Required if question 11 is 'Alcohol', 'Drug', or 'Both')</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
<p>12. Have you ever been told you have a learning disability or developmental disability?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes**	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
<p>12a. Do you expect this to be of long-continued and indefinite duration AND substantially impair your ability to live independently? (Required if question 12 is 'Yes')</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
<p>12b. Do you have documentation of the disability and severity on file? (Required if question 12 is 'Yes')</p>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
<p>12c. Are you currently receiving services or treatment for this condition? (Required if question 12 is 'Yes')</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
<p>13. Do you feel you currently have a mental health problem?</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes**	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
<p>13a. Do you expect this to be of long-continued and indefinite duration AND substantially impair your ability to live independently? (Required if question 13 is 'Yes')</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
<p>13b. Do you have documentation of the disability and severity on file?</p>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

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(Required if question 13 is 'Yes')		
13c. Are you currently receiving services or treatment for this condition? (Required if question 13 is 'Yes')	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected
14. Have you been a victim of domestic violence or a victim of intimate partner violence?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected
14a. How long ago did you have this experience? (Required if question 14 is 'Yes')	<input type="checkbox"/> Within the past three months <input type="checkbox"/> Three to six months ago (excluding six months exactly) <input type="checkbox"/> From six to twelve months ago (excluding one year exactly) <input type="checkbox"/> More than a year ago <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	

EMPLOYMENT: For adults 18 and older or Head of Household < 18 years old, required questions shaded

Question	Check One Answer	Comments
15. Are you currently employed?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
15a. Why are you not employed? (Required if question 15 is 'No')	<input type="checkbox"/> Looking for work <input type="checkbox"/> Unable to work <input type="checkbox"/> Not looking for work	
15b. What type of employment do you have? (Required if question 15 is 'Yes')	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Seasonal / sporadic (including day labor)	

INCOME - Adults aged 18 and older having **NO** financial resources only

Question	Check One Answer	Comments
16. If you do not have an income, and are unable to receive general relief, what's the reason why?	<input type="checkbox"/> Sanctioned <input type="checkbox"/> Time Limits <input type="checkbox"/> Employment	<input type="checkbox"/> Other

PREGNANCY - Women aged 15 and older only

Question	Check One Answer	Comments
17. Are you pregnant?	<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
17a. What is your due date? (Required if question 17 is 'Yes')	____/____/____	

YOUTH - Head of Households aged 17 and under only

Question	Check One Answer	Comments
18. Did you run away from home or a foster care home?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

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VETERAN - US Veterans only, required questions are shaded

Question	Check One Answer	Comments
19. Which branch of the military did you serve in?	<input type="checkbox"/> Army <input type="checkbox"/> Coast Guard <input type="checkbox"/> Air Force <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Navy <input type="checkbox"/> Client Refused <input type="checkbox"/> Marines <input type="checkbox"/> Data not Collected	
20. What type of discharge did you receive?	<input type="checkbox"/> Honorable <input type="checkbox"/> General under honorable conditions <input type="checkbox"/> Other than honorable conditions (OTH) <input type="checkbox"/> Bad Conduct <input type="checkbox"/> Dishonorable <input type="checkbox"/> Uncharacterized <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
21. When did you enter military service?	____ / ____ / ____ <input type="checkbox"/> Doesn't Know	

NOTE: The following questions are required for SSVF programs, but HIGHLY recommended to be completed for all veterans.

22. When did you separate from military service?	____ / ____ / ____ <input type="checkbox"/> Doesn't Know	
23. Household Income as a Percentage of AMI	<input type="checkbox"/> Less than 30% <input type="checkbox"/> 30% to 50% <input type="checkbox"/> Greater than 50%	

Did you serve in any of the following wars/war eras?

24. World War II <i>Dec. 1941 – Dec. 1946</i>	<input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
25. Korean War <i>Jun. 1950 – Jan. 1955</i>	<input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
26. Vietnam War <i>Feb. 1961 – May 1975</i>	<input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
27. Persian Gulf War (Operation Desert Storm) <i>Aug. 1990 – April 1991</i>	<input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
28. Afghanistan (Operation Enduring Freedom) <i>Oct. 2001 - Present</i>	<input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
29. Iraq (Operation Iraqi Freedom) <i>Mar. 2003 – Aug. 2010</i>	<input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
30. Iraq (Operation New Dawn) <i>Sept. 2010 – Dec. 2011</i>	<input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
31. Other Peace-keeping Operations or Military Interventions (such as Lebanon, Panama, Somalia, Bosnia, Kosovo)	<input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	

HMIS Intake and Enrollment Form

Client Name / ID: _____

CHRONIC HOMELESSNESS - Adults aged 18 and older and Head of Household < 18 years old, required questions are shaded

Question	Check One Answer	Comments
<p>ASSESSOR ONLY – DO NOT ASK: 32. Is the client chronically homeless?</p> <p><i>To be chronically homeless, the client must be an unaccompanied homeless individual with a disabling condition or a family with at least one adult member who has a disabling condition who has either been continuously homeless* for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years. To be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency shelter during that time.</i></p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	

I certify that the information above is correct to the best of my knowledge.

Client Signature

Site

Date

Agency Staff Signature

Site

Date

DO NOT WRITE IN BOX BELOW – DATA ENTRY PERSONNEL ONLY (Optional):

Date entered into HMIS: ____/____/____

Question	Answer	Initials of Staff completion	Comments
Was the hard copy exit form completely filled out correctly?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Staff Name (verifying completion of Data Entry): _____