

HMIS Intake and Enrollment Form – CoC/ESG

Client Name / ID: _____

ACCOUNT PROFILE TAB

ACCOUNT INFORMATION	
First Name	Last Name
_____	_____
Date of Birth (mm/dd/yyyy)	SSN
____/____/____	____-____-____
Personal Pronouns (Optional)	
____/____/____ E.g.: She / her / hers; he / him / his	

CONTACT INFORMATION (OPTIONAL)		
Primary Phone Number	Phone Type	
(____)____-____x____	<input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Mobile <input type="checkbox"/> Other <input type="checkbox"/> Leave message
Alternate Phone Number	PhoneType:	
(____)____-____x____	<input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Mobile <input type="checkbox"/> Other <input type="checkbox"/> Leave message
Email Address	Contact Preference	
_____@_____	<input type="checkbox"/> Phone	<input type="checkbox"/> Email <input type="checkbox"/> Text

LAST KNOWN PERMANENT ADDRESS			
What is the address of the place you last lived for 90 days or more? (Not including emergency shelters or transitional housing)			
Address	County	Unit Type	Unit Number
_____	_____	_____	_____
ZIP Code	City	State	
_____	_____	_____	

NOTE		
Subject	Member	Note by
_____	_____	_____
Note Type:	Note Date	Expire Date
<input type="checkbox"/> Alert <input type="checkbox"/> Information	____/____/____	____/____/____
Note:		

HH CONTACTS TAB (Optional)

EMERGENCY— Basic Information			
Relationship to Head of Household	First Name	Middle Name	Last Name
<input type="checkbox"/> Friend <input type="checkbox"/> Neighbor <input type="checkbox"/> Parent <input type="checkbox"/> Medical Doctor <input type="checkbox"/> Babysitter	_____	_____	_____
Email	Primary Phone	Phone Type	
_____@_____	(____)____-____	<input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Mobile <input type="checkbox"/> Other
Address	County	Unit Type	Unit Number
_____	_____	_____	_____

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APPLICATION TAB

Applicant Information

Program Name	Program Start Date
_____	____/____/____
Case Manager	Application Consent
_____	<input type="checkbox"/> System <input type="checkbox"/> Group <input type="checkbox"/> Region <input type="checkbox"/> Privately <input type="checkbox"/> Organization
Comments	

HOUSEHOLD (HH) MEMBERS TAB

Edit Member

Household Type	Household Size	Relationship to Head of Household
<input type="checkbox"/> Households without children <input type="checkbox"/> Households with at least one adult and one child <input type="checkbox"/> Household with only children	Number of clients in Household: _____	<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

Basic Information

First Name	Middle Name	Last Name	Suffix	DOB
_____	_____	_____	<input type="checkbox"/> Sr <input type="checkbox"/> Jr	____/____/____
SSN	Gender	Disabling Condition <i>(Physical, Developmental, Mental Health, Chronic Health Condition, HIV/AIDS, and/or Substance Use Disorder.)</i>	Veteran Status (Have you ever served in the U.S. Military?)	
____-____-____	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Trans Female (MTF or Male to Female) <input type="checkbox"/> Trans Male (FTM or Female to Male) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	<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	<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	

Additional Information

Education Level (What is the highest level of education you've completed?)	Ethnicity	Medical Insurance
<input type="checkbox"/> Less than Grade 5 <input type="checkbox"/> Grades 5-6 <input type="checkbox"/> Grades 7-8 <input type="checkbox"/> Grades 9-11 <input type="checkbox"/> Grade 12 / High school Diploma <input type="checkbox"/> GED <input type="checkbox"/> School program does not have grade levels <input type="checkbox"/> Some College	<input type="checkbox"/> Associates degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Graduate degree <input type="checkbox"/> Vocational Certification <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not collected	<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"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected

Employment Status

<input type="checkbox"/> Employed Full Time <input type="checkbox"/> Migrant Seasonal Farm Worker	<input type="checkbox"/> Unemployed (Short-Term, 6 months or less) <input type="checkbox"/> Unemployed (Long-Term, more than 6 months)	<input type="checkbox"/> Unemployed (Not in Labor Force) <input type="checkbox"/> Retired
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Race (Choose as Many as Applied)					
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian		
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data not Collected		
Data Quality Codes					
Name: Quality Code	<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: Quality Code	<input type="checkbox"/> Full address reported	<input type="checkbox"/> Incomplete or estimated address reported	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected
SSN: Quality Code	<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
Data of Birth: Quality Code	<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

ASSESSMENTS TAB

CoC Entry Questions

Question	Check One Answer
What city were you residing in immediately prior to entry into this project?	<input type="checkbox"/> Aliso Viejo <input type="checkbox"/> El Modena <input type="checkbox"/> Lake Forest <input type="checkbox"/> Santa Ana <input type="checkbox"/> Anaheim <input type="checkbox"/> Fountain Valley <input type="checkbox"/> Las Flores <input type="checkbox"/> Seal Beach <input type="checkbox"/> Atwood <input type="checkbox"/> Fullerton <input type="checkbox"/> Lemon Heights <input type="checkbox"/> Stanton <input type="checkbox"/> Balboa <input type="checkbox"/> Garden Grove <input type="checkbox"/> Los Alamitos <input type="checkbox"/> Sunset Beach <input type="checkbox"/> Brea <input type="checkbox"/> Huntington Beach <input type="checkbox"/> Midway City <input type="checkbox"/> Tustin <input type="checkbox"/> Buena Park <input type="checkbox"/> Irvine <input type="checkbox"/> Mission Viejo <input type="checkbox"/> Villa Park <input type="checkbox"/> Capistrano Beach <input type="checkbox"/> La Habra <input type="checkbox"/> Newport Beach <input type="checkbox"/> Westminster <input type="checkbox"/> Corona del Mar <input type="checkbox"/> La Palma <input type="checkbox"/> Orange <input type="checkbox"/> Yorba Linda <input type="checkbox"/> Costa Mesa <input type="checkbox"/> Laguna Beach <input type="checkbox"/> Placentia <input type="checkbox"/> Outside Orange County <input type="checkbox"/> Coto de Caza <input type="checkbox"/> Laguna Hills <input type="checkbox"/> Rancho Santa Margarita <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Cypress <input type="checkbox"/> Laguna Niguel <input type="checkbox"/> San Clemente <input type="checkbox"/> Client Refused <input type="checkbox"/> Dana Point <input type="checkbox"/> Laguna Woods <input type="checkbox"/> San Juan Capistrano <input type="checkbox"/> Data not Collected
Was the client referred to this project through Coordinated Entry? (Required for Permanent Supportive Housing, Other Permanent Supportive Housing and Rapid Re-Housing projects only)	<input type="checkbox"/> Yes <input type="checkbox"/> No

HUD Questions—GENERAL

Living Situation Questions for Street Outreach, Emergency Shelter, or Safe Haven Projects

1. Type of Residence 3.917A		
<u>HOMELESS SITUATION</u>		
<input type="checkbox"/> Place not meant for human habitation	<input type="checkbox"/> Owned by client, with ongoing housing subsidy	
<input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher	<input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons	
<input type="checkbox"/> Safe Haven	<input type="checkbox"/> Rental by client, no ongoing housing subsidy	
<input type="checkbox"/> Interim Housing	<input type="checkbox"/> Rental by client, with VASH housing subsidy	
<u>INSTITUTIONAL SITUATION</u>	<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 housing subsidy (including RRH)	
<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"/> 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"/> Psychiatric hospital or other psychiatric facility	<input type="checkbox"/> Transitional housing for homeless persons	
<input type="checkbox"/> Substance abuse treatment facility or detox center	<input type="checkbox"/> Client Doesn't Know	
<u>TRANSITIONAL & PERMANENT HOUSING SITUATION</u>	<input type="checkbox"/> Client Refused	
<input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher	<input type="checkbox"/> Data not Collected	
<input type="checkbox"/> Owned by client, no ongoing housing subsidy		
2. Length of Stay in Prior Living Situation		
<input type="checkbox"/> One night or less	<input type="checkbox"/> One month or more, but less than 90 days	<input type="checkbox"/> Client Doesn't Know
<input type="checkbox"/> Two to six nights	<input type="checkbox"/> 90 days or more, but less than one year	<input type="checkbox"/> Client Refused
<input type="checkbox"/> One week or more, but less than one month	<input type="checkbox"/> One year or longer	<input type="checkbox"/> Data not Collected
3. Approximate date homelessness started		
____/____/____		
4. (Regardless of where they stayed last night) Number of times the client has been on the streets, in ES, or SH in the past three years including today		
<input type="checkbox"/> One time	<input type="checkbox"/> Three times	<input type="checkbox"/> Client Doesn't Know
<input type="checkbox"/> Two times	<input type="checkbox"/> Four or more times	<input type="checkbox"/> Client Refused
		<input type="checkbox"/> Data not Collected
5. Total number of months homeless on the street, in ES, or SH in the past three years		
<input type="checkbox"/> One month (this time is the first month)	<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	
<input type="checkbox"/> 6	<input type="checkbox"/> 12	

Living Situation Questions for All Project Types (excluding Street Outreach, Emergency Shelter, or Safe Haven Projects)

1. Type of residence 3.917B

HOMELESS SITUATION

- Place not meant for human habitation
- Emergency Shelter
- Safe Haven
- Interim Housing

Proceed to
Question 5

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

2. Did you stay less than 90 days?

- No
- Yes

Proceed to
Question 8

4. On the night before did you stay on the streets, ES or SH

- No
- Yes

Proceed to
Question 8

Proceed to
Question 5

TRANSITIONAL & PERMANENT HOUSING SITUATION

- Hotel or motel paid for without emergency shelter voucher
- Owned by client, no ongoing housing subsidy
- Owned by client, with ongoing housing subsidy
- Permanent housing (other than RRH) for formerly homeless persons
- Rental by client, no ongoing housing subsidy
- Rental by client, with VASH housing subsidy
- Rental by client, with GPD TIP subsidy
- Rental by client, with other housing subsidy (including RRH)
- 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
- Client Doesn't Know
- Client Refused
- Data not Collected

3. Did you stay less than 7 nights?

- No
- Yes

Proceed to
Question 8

4. On the night before did you stay on the streets, ES or SH

- No
- Yes

Proceed to
Question 8

Proceed to
Question 5

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Client Name / ID: _____

5. Approximate date homelessness started		
____/____/____		
6. Total number of months homeless on the street, in ES, or SH in the past three years		
<input type="checkbox"/> One month (this time is the first month)	<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	
<input type="checkbox"/> 6	<input type="checkbox"/> 12	
7. (Regardless of where they stayed last night) Number of times the client has been on the streets, in ES, or SH in the past three years including today		
<input type="checkbox"/> One time	<input type="checkbox"/> Three times	<input type="checkbox"/> Client Doesn't Know
<input type="checkbox"/> Two times	<input type="checkbox"/> Four or more times	<input type="checkbox"/> Client Refused
		<input type="checkbox"/> Data not Collected
8. Length of Stay in Prior Living Situation		
<input type="checkbox"/> One night or less	<input type="checkbox"/> One month or more, but less than 90 days	<input type="checkbox"/> Client Doesn't Know
<input type="checkbox"/> Two to six nights	<input type="checkbox"/> 90 days or more, but less than one year	<input type="checkbox"/> Client Refused
<input type="checkbox"/> One week or more, but less than one month	<input type="checkbox"/> One year or longer	<input type="checkbox"/> Data not Collected

Question	Check One Answer	Comments
Do you have a physical disability?	<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	
Physical Disability: Expected to substantially impair ability to live independently? (Required if 'Yes' for Physical Disability)	<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	
Do you have a developmental disability?	<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	
If Yes for "Developmental Disability" Expected to substantially impair ability to live independently? (Required if 'Yes' for Developmental Disability)	<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	
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	
Chronic Health Condition: Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? (Required if 'Yes' for 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	
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	
If Yes for "HIV / AIDS" Expected to substantially impair ability to live independently? (Required if 'Yes' for HIV / AIDS)	<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	
Do you feel you have a mental health problem?	<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	

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Client Name / ID: _____

If Yes for "Mental Health Problem" Expected to be of long-continued and indefinite duration AND substantially impair your ability to live independently? (Required if 'Yes' for Mental Health Problem)	<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	
Do you have a drug or alcohol problem?	<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	
Substance Abuse: Expected to be of long-continued and indefinite duration AND substantially impair your ability to live independently? (Required if 'Yes' for Substance Abuse Problem)	<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	
Are you a survivor of domestic or 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	
If Yes for "Domestic Violence Victim/Survivor" When did this experience occurred? (Required if 'Yes' for Domestic Violence)	<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	
Are you currently fleeing? (Required if 'Yes' for Domestic 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	
Permanent Housing — PSH, OPH, RRH		
If client was placed in permanent housing, Housing Move-In Date: (Required for Permanent Supportive Housing, Other Permanent Supportive Housing and Rapid Re-Housing projects only)	_____ / _____ / _____	

INCOME TAB

INCOME							
<input type="checkbox"/> Declare no income	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused			<input type="checkbox"/> Data not collected		
Income Source (Check all that apply)	Frequency						Stated Income
	Weekly	Every Other Week	Twice a Month	Monthly	Quarterly	Yearly	
<input type="checkbox"/> No financial resources							
<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 (<i>GA</i>) (<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"/>	\$

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<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"/>	\$
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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"/> SNAP Amount: _____	<input type="checkbox"/> CalWorks Child Care	<input type="checkbox"/> WIC
<input type="checkbox"/> CalWorks Transportation	<input type="checkbox"/> Other CalWorks-Funded Services	<input type="checkbox"/> Other Amount: _____

HEALTH INSURANCE (Check all that apply):

<input type="checkbox"/> No Health Insurance	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data not Collected
<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> MEDICARE _____	<input type="checkbox"/> VA Medical Services
<input type="checkbox"/> Medicaid _____	<input type="checkbox"/> Employer Provided Health Insurance	<input type="checkbox"/> COBRA Health Ins.
<input type="checkbox"/> State Children's Health Insurance	<input type="checkbox"/> State Adult Health Insurance	<input type="checkbox"/> Indian Health Services Program
<input type="checkbox"/> Private Health Insurance		
<input type="checkbox"/> Other _____		

*Please select State Adult Health Insurance if the client receives MediCal

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 intake form completely filled out correctly?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Staff Name (verifying completion of Data Entry): _____