

# HMIS Intake and Enrollment Form - RHY

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"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Other <input type="checkbox"/> Leave message	
Alternate Phone Number		PhoneType:	
(____)____-____x____		<input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work <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
_____		_____	_____
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
<input type="checkbox"/> Friend <input type="checkbox"/> Medical Doctor <input type="checkbox"/> Neighbor <input type="checkbox"/> Babysitter		_____	_____
			Last Name
			_____
Email		Primary Phone	Phone Type
_____@_____		(____)____-____	<input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Other
Address		County	Unit Type
_____		_____	_____
Address		Unit Number	
_____		_____	

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## APPLICATION TAB

### Applicant Information

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

## HOUSEHOLD (HH) MEMBERS TAB

### Edit Member

<b>Household Type</b>	<b>Household Size</b>	<b>Relationship to Head of Household</b>
<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

<b>First Name</b> _____	<b>Middle Name</b> _____	<b>Last Name</b> _____	<b>Suffix</b> <input type="checkbox"/> Sr <input type="checkbox"/> Jr	<b>DOB</b> ____/____/____
<b>SSN</b> ____-____-____	<b>Gender</b> <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	<b>Disabling Condition</b> <i>(Physical, Developmental, Mental Health, Chronic Health Condition, HIV/AIDS, and/or Substance Use Disorder.)</i> <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	<b>Veteran Status</b> (Have you ever served in the U.S. Military?) <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

<b>Education Level</b> (What is the highest level of education you've completed?)	<b>Ethnicity</b>	<b>Medical Insurance</b>
<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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Client Name / ID: \_\_\_\_\_

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					
<b>Name: Quality Code</b>	<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
<b>Address: Quality Code</b>	<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
<b>SSN: Quality Code</b>	<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
<b>Data of Birth: Quality Code</b>	<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? <b>(Required for Permanent Supportive Housing, Other Permanent Supportive Housing and Rapid Re-Housing projects only)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

## HUD Questions—GENERAL

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

<b>1. Type of Residence 3.917A</b>		
<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 &amp; 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		
<b>2. Length of Stay in Prior Living Situation</b>		
<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
<b>3. Approximate date homelessness started</b>		
____/____/____		
<b>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</b>		
<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
<b>5. Total number of months homeless on the street, in ES, or SH in the past three years</b>		
<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	

# HMIS Intake and Enrollment Form - RHY

Client Name / ID: \_\_\_\_\_

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

### 1. Type of residence 3.917B

<p><b>HOMELESS SITUATION</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Place not meant for human habitation</li><li><input type="checkbox"/> Emergency Shelter</li><li><input type="checkbox"/> Safe Haven</li><li><input type="checkbox"/> Interim Housing</li></ul>	<p>Proceed to <b>Question 5</b></p>		
<p><b>INSTITUTIONAL SITUATION</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Foster care home or foster care group home</li><li><input type="checkbox"/> Hospital or other residential non-psychiatric medical facility</li><li><input type="checkbox"/> Jail, prison or juvenile detention facility</li><li><input type="checkbox"/> Long-term care facility or nursing home</li><li><input type="checkbox"/> Psychiatric hospital or other psychiatric facility</li><li><input type="checkbox"/> Substance abuse treatment facility or detox center</li></ul>	<p><b>2. Did you stay less than 90 days?</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> No</li><li><input type="checkbox"/> Yes</li></ul>	<p>Proceed to <b>Question 8</b></p>	
		<p><b>4. On the night before did you stay on the streets, ES or SH</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> No</li><li><input type="checkbox"/> Yes</li></ul>	<p>Proceed to <b>Question 8</b></p>
			<p>Proceed to <b>Question 5</b></p>
<p><b>TRANSITIONAL &amp; PERMANENT HOUSING SITUATION</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher</li><li><input type="checkbox"/> Owned by client, no ongoing housing subsidy</li><li><input type="checkbox"/> Owned by client, with ongoing housing subsidy</li><li><input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons</li><li><input type="checkbox"/> Rental by client, no ongoing housing subsidy</li><li><input type="checkbox"/> Rental by client, with VASH housing subsidy</li><li><input type="checkbox"/> Rental by client, with GPD TIP subsidy</li><li><input type="checkbox"/> Rental by client, with other housing subsidy (including RRH)</li><li><input type="checkbox"/> Residential project or halfway house with no homeless criteria</li><li><input type="checkbox"/> Staying or living in a family member's room, apartment, or house</li><li><input type="checkbox"/> Staying or living in a friend's room, apartment, or house</li><li><input type="checkbox"/> Transitional housing for homeless persons</li><li><input type="checkbox"/> Client Doesn't Know</li><li><input type="checkbox"/> Client Refused</li><li><input type="checkbox"/> Data not Collected</li></ul>	<p><b>3. Did you stay less than 7 nights?</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> No</li><li><input type="checkbox"/> Yes</li></ul>	<p>Proceed to <b>Question 8</b></p>	
		<p><b>4. On the night before did you stay on the streets, ES or SH</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> No</li><li><input type="checkbox"/> Yes</li></ul>	<p>Proceed to <b>Question 8</b></p>
			<p>Proceed to <b>Question 5</b></p>

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Client Name / ID: \_\_\_\_\_

<b>5. Approximate date homelessness started</b>		
____/____/____		
<b>6. Total number of months homeless on the street, in ES, or SH in the past three years</b>		
<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	
<b>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</b>		
<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
<b>8. Length of Stay in Prior Living Situation</b>		
<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? <b>(Required if 'Yes' for Physical Disability)</b>	<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? <b>(Required if 'Yes' for Developmental Disability)</b>	<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? <b>(Required if 'Yes' for Chronic Health Condition)</b>	<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	
If Yes for "Mental Health Problem" Expected to be of long-continued and indefinite duration AND substantially impair your ability to live independently? <b>(Required if 'Yes' for Mental Health Problem)</b>	<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	

# HMIS Intake and Enrollment Form - RHY

Client Name / ID: \_\_\_\_\_

Substance Abuse: Expected to be of long-continued and indefinite duration AND substantially impair your ability to live independently? <b>(Required if 'Yes' for Substance Abuse Problem)</b>	<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
--	---	--

## RHY

Question	Check One Answer	Comments
Sexual Orientation	<input type="checkbox"/> Heterosexual <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual	<input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not Collected
School Status	<input type="checkbox"/> Attending school regularly <input type="checkbox"/> Attending school irregularly <input type="checkbox"/> Graduated from high school <input type="checkbox"/> Obtained GED <input type="checkbox"/> Dropped Out	<input type="checkbox"/> Suspended <input type="checkbox"/> Expelled <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not Collected
Employment Status	<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, what type of employment do you have? <b>(Required if 'Currently Employed' is Yes)</b>	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Seasonal / sporadic (including day labor)	
If no, Why are you not employed? <b>(Required if 'Currently Employed' is No)</b>	<input type="checkbox"/> Looking for work <input type="checkbox"/> Unable to work <input type="checkbox"/> Not looking for work	
General Health Status	<input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair	<input type="checkbox"/> Poor <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not Collected
Dental Health Status	<input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair	<input type="checkbox"/> Poor <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not Collected
Mental Health Status	<input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair	<input type="checkbox"/> Poor <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not Collected
Are you pregnant? <b>(Required only for females over 18, head of household or unaccompanied youth)</b>	<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
What is your due date?	_____/_____/_____	
Formerly a Ward of Child Welfare or Foster Care Agency	<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 'Formerly a Ward of Child Welfare or Foster Care Agency', Number of Years	<input type="checkbox"/> Less than one year <input type="checkbox"/> 1 to 2 years	

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Client Name / ID: \_\_\_\_\_

<p><b>(Required if 'Formerly a Ward of Child Welfare or Foster Care Agency' is Yes)</b></p>	<input type="checkbox"/> 3 to 5 or more years	
<p>If 'Less than one year' for 'Number of Years', Number of Months</p> <p><b>(Required 'Number of Years' is 'Less than one year')</b></p>	<input type="checkbox"/> 1 <input type="checkbox"/> 5 <input type="checkbox"/> 9 <input type="checkbox"/> 2 <input type="checkbox"/> 6 <input type="checkbox"/> 10 <input type="checkbox"/> 3 <input type="checkbox"/> 7 <input type="checkbox"/> 11 <input type="checkbox"/> 4 <input type="checkbox"/> 8	
<p>Formerly a Ward of Juvenile Justice System</p>	<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	
<p>If Yes for 'Formerly a Ward of the Juvenile Justice System', Number of Years</p> <p><b>(Required if "Formerly a Ward of the Juvenile Justice System" is Yes)</b></p>	<input type="checkbox"/> Less than one year <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 3 to 5 or more years	
<p>If 'Less than one year' for 'Number of Years', Number of Months</p> <p><b>(Required 'Number of Years' is 'Less than one year')</b></p>	<input type="checkbox"/> 1 <input type="checkbox"/> 5 <input type="checkbox"/> 9 <input type="checkbox"/> 2 <input type="checkbox"/> 6 <input type="checkbox"/> 10 <input type="checkbox"/> 3 <input type="checkbox"/> 7 <input type="checkbox"/> 11 <input type="checkbox"/> 4 <input type="checkbox"/> 8	
<p>Family critical issues</p>	<input type="checkbox"/> Unemployment - Family member <input type="checkbox"/> Mental Health Issues-Family member <input type="checkbox"/> Physical Disability- Family member <input type="checkbox"/> Alcohol or Substance Abuse- Family member <input type="checkbox"/> Insufficient Income to support youth - Family member <input type="checkbox"/> Incarcerated Parent of Youth	
<p>Referral Source</p>	<input type="checkbox"/> Self-Referral <input type="checkbox"/> Individual: Parent/Guardian/Relative/Friend/Foster Parent/Other Individual <input type="checkbox"/> Outreach Project <input type="checkbox"/> Temporary Shelter <input type="checkbox"/> Residential Project <input type="checkbox"/> Hotline <input type="checkbox"/> Child Welfare/CPS <input type="checkbox"/> Juvenile Justice <input type="checkbox"/> Law Enforcement/ Police <input type="checkbox"/> Mental Hospital <input type="checkbox"/> School <input type="checkbox"/> Other Organization <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not Collected	
<p>If 'Outreach Project' is selected for Referral Source, Number of times approached by outreach prior to entering the project</p> <p><b>(Required 'Referral Source' is 'Outreach Project')</b></p>	_____ times	



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BCP		
Date of RHY-BCP Status Determination <b>(Required for ES or HP Projects only)</b>	_____ / _____ / _____	
Youth Eligible for RHY Services <b>(Required for ES or HP Projects only)</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
If No for 'Youth Eligible for RHY Services', Reason why services are not funded by BCP grant <b>(Required if 'Youth Eligible for RHY Services' is No)</b>	<input type="checkbox"/> Out of age range <input type="checkbox"/> Ward of the State – Immediate Reunification <input type="checkbox"/> Ward of the Criminal Justice System – Immediate Reunification <input type="checkbox"/> Other	
If Yes for "Youth Eligible for RHY Services", Runaway youth <b>(Required if 'Youth Eligible for RHY Services' is Yes)</b>	<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	

## INCOME TAB

### INCOME

<input type="checkbox"/> <b>Declare no income</b>	<input type="checkbox"/> <b>Client doesn't know</b>	<input type="checkbox"/> <b>Client refused</b>	<input type="checkbox"/> <b>Data not collected</b>				
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"/>	\$
<input type="checkbox"/> Other Source (Specify: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$

### NON-CASH BENEFITS (Check all that apply):

<input type="checkbox"/> <b>None</b>		
<input type="checkbox"/> <b>Client doesn't know</b>	<input type="checkbox"/> <b>Client Refused</b>	<input type="checkbox"/> <b>Data not Collected</b>
<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"/> <b>No Health Insurance</b>	<input type="checkbox"/> <b>Client Refused</b>	<input type="checkbox"/> <b>Data not Collected</b>
<input type="checkbox"/> <b>Client Doesn't Know</b>	<input type="checkbox"/> <b>MEDICARE</b> _____	<input type="checkbox"/> <b>VA Medical Services</b>
<input type="checkbox"/> Medicaid _____	<input type="checkbox"/> <b>Employer Provided Health Insurance</b>	<input type="checkbox"/> <b>COBRA Health Ins.</b>
<input type="checkbox"/> State Children's Health Insurance	<input type="checkbox"/> <b>State Adult Health Insurance</b>	<input type="checkbox"/> <b>Indian Health Services Program</b>
<input type="checkbox"/> Private Health Insurance		
<input type="checkbox"/> Other _____		

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

# HMIS Intake and Enrollment Form - RHY

Client Name / ID: \_\_\_\_\_

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): \_\_\_\_\_