

# FY 2022 OC HMIS: PROJECT INTAKE FORM — HOPWA

## CLIENT PROFILE

<b>SOCIAL SECURITY NUMBER (SSN)</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 12.5%; height: 20px;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%; text-align: center;">—</td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%; text-align: center;">—</td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>				—			—			
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**QUALITY OF SSN**

<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
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<b>CLIENT'S NAME</b>	<b>N/A</b>
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<b>Last</b>																	<input type="checkbox"/>	
<b>First</b>																		
<b>Middle</b>																		<input type="checkbox"/>
<b>Suffix</b>																		<input type="checkbox"/>

**QUALITY OF NAME**

<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
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<b>DATE OF BIRTH</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%; text-align: center;">—</td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%; text-align: center;">—</td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td> <td style="width: 10%;"><b>Age:</b></td> </tr> <tr> <td style="text-align: center;">Month</td><td></td><td></td><td style="text-align: center;">Day</td><td></td><td></td><td style="text-align: center;">Year</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>			—			—												<b>Age:</b>	Month			Day			Year											
		—			—												<b>Age:</b>																				
Month			Day			Year																															

**QUALITY OF DOB**

<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
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**GENDER** (Select all that apply)

<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> A gender that is not singularly 'Female' or 'Male' <input type="checkbox"/> Transgender <input type="checkbox"/> Questioning	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
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**RACE** (Select all that apply)

<input type="checkbox"/> White <input type="checkbox"/> Black, African American, or African	<input type="checkbox"/> American Indian, Alaska Native, or Indigenous <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Asian or Asian American	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
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**ETHNICITY**

<input type="checkbox"/> Non-Hispanic/Latin(a)(o)(x) <input type="checkbox"/> Hispanic/Latin(a)(o)(x)	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
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**VETERAN 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
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**If 'YES' to Veteran Status**

Year entered military service (year)	_____
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Year separated from military service (year)	_____
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<b>Theater of Operations: World War II</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

<b>Theater of Operations: Korean War</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

<b>Theater of Operations: Vietnam War</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

<b>Theater of Operations: Persian Gulf War</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

<b>Theater of Operations: Afghanistan</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

<b>Theater of Operations: Iraq (Operation Iraqi Freedom)</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

<b>Theater of Operations: Iraq (Operation New Dawn)</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

<b>Theater of Operations: Other peace-keeping operations or military interventions (such as Lebanon, Panama, Somalia, Bosnia, Kosovo)</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

<b>Branch of the Military</b>		
<input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Navy	<input type="checkbox"/> Marines <input type="checkbox"/> Coast Guard	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

<b>Discharge Status</b>		
<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

## OC OPTIONAL QUESTIONS

<b>Alias</b>	_____	
<b>Pronouns(s)</b>	<input type="checkbox"/> She/Her/Hers <input type="checkbox"/> He/Him/His	<input type="checkbox"/> They/Them/Theirs <input type="checkbox"/> Other: _____

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## PROJECT ENROLLMENT

### RELATIONSHIP TO HEAD OF HOUSEHOLD

<input type="checkbox"/> Self (head of household) <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
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<b>PROJECT NAME</b>										
<b>PROJECT START DATE</b>	<table border="1"> <tr> <td></td><td></td><td>—</td><td></td><td></td><td>—</td><td></td><td></td><td></td> </tr> </table>			—			—			
		—			—					
<b>HOUSING MOVE-IN DATE</b> <i>(For PSH, PH with no disability requirement, and RRH Projects: Record the date a client or household moves into a permanent housing unit)</i>	<table border="1"> <tr> <td></td><td></td><td>—</td><td></td><td></td><td>—</td><td></td><td></td><td></td> </tr> </table>			—			—			
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### PRIOR LIVING SITUATION for *Street Outreach, Emergency Shelter, or Safe Haven* project types

<b>Type of Residence 3.917A</b> <i>(Type of living arrangement on the night before entering this project)</i>		
<b>HOMELESS SITUATION</b>		
<input type="checkbox"/> Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter <input type="checkbox"/> Safe Haven		
<b>INSTITUTIONAL SITUATION</b>		
<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"/> Jail, prison or juvenile detention facility		
<input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center		
<b>TRANSITIONAL &amp; PERMANENT HOUSING SITUATION</b>		
<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"/> Transitional housing for homeless persons (including Homeless Youth) <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Staying or living in a friend's room, apartment or house <input type="checkbox"/> Staying or living in a family member's room, apartment, or house <input type="checkbox"/> Rental by client, with GPD TIP subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons		
<input type="checkbox"/> Rental by client, with RRH or equivalent subsidy <input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based) <input type="checkbox"/> Rental by client in a public housing unit <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected		
<b>Length of Stay in Prior Living Situation</b> <i>(How long ago did the client start staying in that Type of Residence)</i>		
<input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more, but less than one month	<input type="checkbox"/> One month or more, but less than 90 days <input type="checkbox"/> 90 days or more, but less than one year <input type="checkbox"/> One year or longer	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

If Client's Type of Residence is any of the *Institutional Situation* options:

<b>Length of Stay Less than 90 days?</b> <i>(Indicate if the stay in the institutional setting they lived in immediately prior to project entry was less than 90 days)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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If 'Length of Stay Less than 90 days' is YES

<b>On the night before – stayed on streets, ES or Safe Haven?</b> <i>(On the night before the client's stay of less than 90 days in an institutional setting were they on the streets, in an Emergency Shelter, or in a Safe Haven?)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
---	-----------------------------	------------------------------

<b>Approximate Date Homelessness Started</b> <i>(Approximate date the client's current episode of homelessness began)</i>
____/____/____

<b>Number of times the client has been on the streets, in ES, or Save Haven in the past three years including today</b> <i>(Regardless of where they stayed last night)</i>		
<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>Total number of months homeless on the streets, in ES, or SH in the past three years</b>		
<input type="checkbox"/> One month (this time is the first month)	<input type="checkbox"/> Six Months	<input type="checkbox"/> Eleven Months
<input type="checkbox"/> Two Months	<input type="checkbox"/> Seven Months	<input type="checkbox"/> Twelve Months
<input type="checkbox"/> Three Months	<input type="checkbox"/> Eight Months	<input type="checkbox"/> More than 12 months
<input type="checkbox"/> Four Months	<input type="checkbox"/> Nine Months	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Five Months	<input type="checkbox"/> Ten Months	<input type="checkbox"/> Client refused
<input type="checkbox"/> Data not collected		

## PRIOR LIVING SITUATION for project types other than Street Outreach, Emergency Shelter, or Safe Haven

<b>Type of Residence 3.917B</b> <i>(Type of living arrangement on the night before the entry into the project)</i>	
<b>HOMELESS SITUATION</b>	
<input type="checkbox"/> Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter <input type="checkbox"/> Safe Haven	
<b>INSTITUTIONAL SITUATION</b>	
<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"/> Jail, prison or juvenile detention facility	<input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center
<b>TRANSITIONAL AND PERMANENT HOUSING SITUATION</b>	
<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"/> Transitional housing for homeless persons (including Homeless Youth) <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Staying or living in a friend's room, apartment or house <input type="checkbox"/> Staying or living in a family member's room, apartment, or house <input type="checkbox"/> Rental by client, with GPD TIP subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons	<input type="checkbox"/> Rental by client, with RRH or equivalent subsidy <input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based) <input type="checkbox"/> Rental by client in a public housing unit <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

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Length of Stay in Prior Living Situation (How long ago did the client start staying in that Type of Residence)		
<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

If Client's Type of Residence is any of the Homeless Situation options:

Approximate Date Homelessness Started (Approximate date the client's current episode of homelessness began)		
____ / ____ / ____		
Number of times the client has been on the streets, in ES, or Save Haven in the past three years including today (Regardless of where they stayed last night)		
<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
Total number of months homeless on the streets, in ES, or SH in the past three years		
<input type="checkbox"/> One month (this time is the first month)	<input type="checkbox"/> Six Months	<input type="checkbox"/> Eleven Months
<input type="checkbox"/> Two Months	<input type="checkbox"/> Seven Months	<input type="checkbox"/> Twelve Months
<input type="checkbox"/> Three Months	<input type="checkbox"/> Eight Months	<input type="checkbox"/> More than 12 months
<input type="checkbox"/> Four Months	<input type="checkbox"/> Nine Months	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Five Months	<input type="checkbox"/> Ten Months	<input type="checkbox"/> Client refused
		<input type="checkbox"/> Data not collected

If Client's Type of Residence is any of the Institutional Situation options:

Length of Stay Less than 90 days? (Indicate if the stay in the institutional setting they lived in immediately prior to project entry was less than 90 days)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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If Client's Type of Residence is any of the Transitional and Permanent Housing Situation options:

Length of Stay Less than 7 nights? (Indicate if the stay in the transitional or permanent housing setting they lived in immediately prior to project entry was less than 7 nights)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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If 'Length of Stay Less than 90 days' is YES—OR— If 'Length of Stay Less than 7 nights' is YES

On the night before – stayed on streets, ES or Safe Haven? (On the night before the client's stay of less than 90 days in an institutional setting, or less than 7 nights in a transitional/permanent housing setting, were they on the streets, in an Emergency Shelter, or in a Safe Haven?)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
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If 'On the night before – stayed on streets, ES, or Safe Haven' is YES

Approximate Date Homelessness Started (Approximate date the client's current episode of homelessness began)		
____ / ____ / ____		
Number of times the client has been on the streets, in ES, or Save Haven in the past three years including today (Regardless of where they stayed last night)		
<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

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Total number of months homeless on the streets, in ES, or SH in the past three years		
<input type="checkbox"/> One month (this time is the first month)	<input type="checkbox"/> Six Months	<input type="checkbox"/> Eleven Months
<input type="checkbox"/> Two Months	<input type="checkbox"/> Seven Months	<input type="checkbox"/> Twelve Months
<input type="checkbox"/> Three Months	<input type="checkbox"/> Eight Months	<input type="checkbox"/> More than 12 months
<input type="checkbox"/> Four Months	<input type="checkbox"/> Nine Months	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Five Months	<input type="checkbox"/> Ten Months	<input type="checkbox"/> Client refused
		<input type="checkbox"/> Data not collected

## DISABLING CONDITIONS AND BARRIERS

**Do you have a disabling condition?**

<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

**Do you have a physical disability?**

<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
<i>If yes for Physical Disability, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?</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

**Do you have a developmental disability?**

<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

**Do you have a chronic health condition?**

<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
<i>If yes for Chronic Health Condition, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?</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

**Have you been diagnosed with AIDS or have you tested positive for HIV?**

<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

**Do you have a mental health problem?**

<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
<i>If yes for Mental Health Problem, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?</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

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## Do you have a substance abuse problem?

<input type="checkbox"/> No <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol and Drug		<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<i>If you have any Substance Abuse Problem, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?</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

## 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
<i>If Yes for survivor of domestic or intimate partner violence</i>		
<b>When did this experience occur?</b>	<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
<b>Are you currently fleeing?</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

## MONTHLY INCOME AND SOURCES

<b>Income from Any Source</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
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### IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY

Income Source (Check all that apply)	Monthly Amount
<input type="checkbox"/> Earned Income	
<input type="checkbox"/> Unemployment Insurance	
<input type="checkbox"/> Worker's Compensation	
<input type="checkbox"/> Private Disability Insurance	
<input type="checkbox"/> VA Service-Connected Disability Compensation	
<input type="checkbox"/> Social Security Disability Income (SSDI)	
<input type="checkbox"/> Supplemental Security Income (SSI)	
<input type="checkbox"/> Retirement Income from Social Security	
<input type="checkbox"/> VA Non-Service-Connected Disability Pension	
<input type="checkbox"/> Pension or retirement income from a former job	
<input type="checkbox"/> Temporary Assistance for Needy Families (TANF)	
<input type="checkbox"/> General Assistance (GA)	
<input type="checkbox"/> Alimony or other spousal support	
<input type="checkbox"/> Child Support	
<input type="checkbox"/> Other Cash Income (Specify: _____)	

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## NON-CASH BENEFITS

<b>Receiving Non-Cash Benefits?</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
<b>IF "YES" TO RECEIVING NON-CASH BENEFITS– INDICATE ALL SOURCES THAT APPLY</b>		
<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP)	<input type="checkbox"/> TANF Transportation Services	
<input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	<input type="checkbox"/> Other TANF-funded services	
<input type="checkbox"/> TANF Childcare Services	<input type="checkbox"/> Other Non-Cash Benefits (Specify Source): _____	

## HEALTH INSURANCE

<b>Covered by Health Insurance?</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
<b>IF "YES" TO COVERED BY HEALTH INSURANCE– INDICATE ALL SOURCES THAT APPLY</b>		
<input type="checkbox"/> MEDICAID	<b>If not covered by MEDICAID, REASON</b>	
	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<input type="checkbox"/> MEDICARE	<b>If not covered by MEDICARE, REASON</b>	
	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<input type="checkbox"/> State Children's Health Insurance Program	<b>If not covered by State Children's Health Insurance Program, REASON</b>	
	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<input type="checkbox"/> Veteran's Administration (VA) Medical Services	<b>If not covered by Veteran's Administration (VA) Medical Services, REASON</b>	
	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<input type="checkbox"/> Employer-provided Health Insurance	<b>If not covered by Employer-provided Health Insurance, REASON</b>	
	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<input type="checkbox"/> Insurance Obtained through COBRA	<b>If not covered by Insurance Obtained through COBRA, REASON</b>	
	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected



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<input type="checkbox"/> Private Pay Health Insurance	If not covered by Private Pay Health Insurance, <b>REASON</b>	
	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<input type="checkbox"/> State Health Insurance for Adults	If not covered by State Health Insurance for Adults, <b>REASON</b>	
	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<input type="checkbox"/> Indian Health Services Program	If not covered by Indian Health Services Program, <b>REASON</b>	
	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<input type="checkbox"/> Other Health Insurance	(Specify Source): _____	

If you have been diagnosed with AIDS or have you tested positive for HIV

## MEDICAL ASSISTANCE

<b>Receiving Public HIV/AIDS Medical Assistance?</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
<b>IF "NO" TO RECEIVING PUBLIC HIV/AIDS MEDICAL ASSISTANCE – REASON</b>		
<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected	
<b>Receiving AIDS Drug Assistance Program (ADAP)?</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
<b>IF "NO" TO RECEIVING AIDS DRUG ASSISTANCE PROGRAM (ADAP) – REASON</b>		
<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected	
<b>Receiving Ryan White-funded Medical or Dental Assistance?</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
<b>IF "NO" TO RECEIVING RYAN WHITE-FUNDED MEDICAL OR DENTAL ASSISTANCE – REASON</b>		
<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected	

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## T-CELL (CD4) AND VIRAL LOAD

<b>T-cell (CD4) Count Available</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
If Yes for 'T-cell (CD4) Count Available', <b>T-cell Count (Number between 0-1500)</b>	Number: _____	
If a number is entered in the T-Cell (CD4) count, <b>How was the information obtained</b>	<input type="checkbox"/> Medical report <input type="checkbox"/> Client report <input type="checkbox"/> Other	
<b>Viral Load Information Available</b>	<input type="checkbox"/> Not available <input type="checkbox"/> Available <input type="checkbox"/> Undetectable	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
If "Viral Load Information Available", <b>Viral Load (Number between 0-999999)</b>	Number: _____	
If a number is entered in the Viral Load count, <b>How was the information obtained</b>	<input type="checkbox"/> Medical report <input type="checkbox"/> Client report <input type="checkbox"/> Other	

## PRESCRIBED ANTI-RETROVIRAL

<b>Has the participant been prescribed anti-retroviral drugs?</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
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## OC CUSTOM QUESTIONS

<b>What city were you in immediately prior to entry into this project?</b>			
<i>The city in which the client spent the night prior to entry into this project</i>			
<input type="checkbox"/> Aliso Viejo	<input type="checkbox"/> Huntington Beach	<input type="checkbox"/> Newport Beach	<input type="checkbox"/> Westminster
<input type="checkbox"/> Anaheim	<input type="checkbox"/> Irvine	<input type="checkbox"/> Orange	<input type="checkbox"/> Yorba Linda
<input type="checkbox"/> Brea	<input type="checkbox"/> La Habra	<input type="checkbox"/> Placentia	<input type="checkbox"/> Unincorporated Orange County
<input type="checkbox"/> Buena Park	<input type="checkbox"/> La Palma	<input type="checkbox"/> Rancho Santa Margarita	<input type="checkbox"/> Outside Orange County, but in California
<input type="checkbox"/> Costa Mesa	<input type="checkbox"/> Laguna Beach	<input type="checkbox"/> San Clemente	<input type="checkbox"/> Outside of California
<input type="checkbox"/> Cypress	<input type="checkbox"/> Laguna Hills	<input type="checkbox"/> San Juan Capistrano	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Dana Point	<input type="checkbox"/> Laguna Niguel	<input type="checkbox"/> Santa Ana	<input type="checkbox"/> Client Refused
<input type="checkbox"/> El Modena	<input type="checkbox"/> Laguna Woods	<input type="checkbox"/> Seal Beach	<input type="checkbox"/> Data not collected
<input type="checkbox"/> Fountain Valley	<input type="checkbox"/> Lake Forest	<input type="checkbox"/> Stanton	
<input type="checkbox"/> Fullerton	<input type="checkbox"/> Los Alamitos	<input type="checkbox"/> Tustin	
<input type="checkbox"/> Garden Grove	<input type="checkbox"/> Mission Viejo	<input type="checkbox"/> Villa Park	
<b>Phone Number (Optional)</b>			
<b>Email Address (Optional)</b>			

<b>What state were you born in?</b>
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<input type="checkbox"/> AL - Alabama	<input type="checkbox"/> GA - Georgia	<input type="checkbox"/> MA - Massachusetts	<input type="checkbox"/> NM - New Mexico	<input type="checkbox"/> TN - Tennessee
<input type="checkbox"/> AL- Alaska	<input type="checkbox"/> HI - Hawaii	<input type="checkbox"/> MI - Michigan	<input type="checkbox"/> NY - New York	<input type="checkbox"/> TX - Texas
<input type="checkbox"/> AZ - Arizona	<input type="checkbox"/> ID - Idaho	<input type="checkbox"/> MN - Minnesota	<input type="checkbox"/> NC - North Carolina	<input type="checkbox"/> UT - Utah
<input type="checkbox"/> AR- Arkansas	<input type="checkbox"/> IL - Illinois	<input type="checkbox"/> MS - Mississippi	<input type="checkbox"/> ND - North Dakota	<input type="checkbox"/> VT - Vermont
<input type="checkbox"/> CA - California	<input type="checkbox"/> IN - Indiana	<input type="checkbox"/> MO - Missouri	<input type="checkbox"/> OH - Ohio	<input type="checkbox"/> VA - Virginia
<input type="checkbox"/> CO - Colorado	<input type="checkbox"/> IA - Iowa	<input type="checkbox"/> MT - Montana	<input type="checkbox"/> OK - Oklahoma	<input type="checkbox"/> WA - Washington
<input type="checkbox"/> CT- Connecticut	<input type="checkbox"/> KS - Kansas	<input type="checkbox"/> NE - Nebraska	<input type="checkbox"/> OR - Oregon	<input type="checkbox"/> WV - West Virginia
<input type="checkbox"/> DE - Delaware	<input type="checkbox"/> KY - Kentucky	<input type="checkbox"/> NV - Nevada	<input type="checkbox"/> PA - Pennsylvania	<input type="checkbox"/> WI - Wisconsin
<input type="checkbox"/> DC - District of Columbia	<input type="checkbox"/> LA - Louisiana	<input type="checkbox"/> NH - New Hampshire	<input type="checkbox"/> RI - Rhode Island	<input type="checkbox"/> WY - Wyoming
<input type="checkbox"/> FL - Florida	<input type="checkbox"/> ME - Maine	<input type="checkbox"/> NJ - New Jersey	<input type="checkbox"/> SC - South Carolina	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> MD - Maryland		<input type="checkbox"/> SD - South Dakota	<input type="checkbox"/> Client Refused
				<input type="checkbox"/> Other

If 'Other' for State you were born, <b>Which country were you born in?</b>	
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<b>Employment Status</b>	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Seasonal/Temporary Work	<input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Retired	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not collected
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I certify that the information above is correct to the best of my knowledge.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agency Staff Signature

\_\_\_\_\_  
Date

**DO NOT ANSWER QUESTIONS BELOW – DATA ENTRY PERSONNEL ONLY (Optional):**

Date entered into HMIS: \_\_\_\_/\_\_\_\_/\_\_\_\_

Question	Answer	Comments
<b>Was the hard copy intake form completely filled out correctly?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes	

Staff Name (verifying completion of Data Entry): \_\_\_\_\_