

Carolina Homeless Information Network

Client ID # _____

www.nhomeless.org * support@nhomeless.org * 877-703-3176
HMIS Intake Form

Consent Expiration Date _____

HMIS Data Entry Process

Profile - enter the basic demographic information

Household - if there are additional members, create a household and add their Profile information

ROI - enter the consent from the client *If you also enter non-HPRP clients, make sure to enter 1 consent for your agency and 1 consent for HPRP

Entry/Exit - To record enrollment in a program

Services/Shelter - record services in Service Transactions, shelter stays in ShelterPoint

HMIS Profile Information (collect for each member of the household)

FIRST NAME _____ MI _____ LAST NAME _____ SUFFIX _____

SSN _____
SSN DATA QUALITY Full SSN Reported Partial SSN Reported Don't Know/Don't Have Refused

DOB _____ DOB TYPE Full DOB Reported Approximate/Partial Don't Know

GENDER Male Female Transgender M-F Transgender F-M Unknown Don't know Refused

RACE (1st box=Primary 2nd box=and Secondary, if recorded)
 American Indian/Alaska Native Asian Black/African-American Native Hawaiian/Other Pacific Islander White
 Don't Know Refused

HOME PHONE/CONTACT NUMBER _____

DRIVERS LICENSE/ID NUMBER _____ ISSUING STATE FOR ID _____

NON-CONFIDENTIAL NOTES

COUNTY OF ORIGIN _____

HMIS Program Information (collect for head of household and use Household Data Sharing to push answers to other members)

ENROLLMENT START DATE _____ NAME OF PROGRAM _____

US MILITARY VETERAN Yes No Don't Know Refused HAS CLIENT SERVED IN THE MILITARY Yes No Don't Know Refused

DOMESTIC VIOLENCE VICTIM Yes No Don't Know Refused
EXTENT OF DOMESTIC VIOLENCE Within past 3 mos 3 to 6 mos ago 6 to 12 mos ago More than 1 year ago
 Don't Know Refused

IS CLIENT HOMELESS Yes No Don't Know Refused
CLIENT CHRONICALLY HOMELESS Yes No Don't Know Refused
IS JUVENILE PARENT Yes No Don't Know Refused
HOUSING STATUS Literally Homeless Housed & At Risk of Homelessness Don't Know
 Housed & At Imminent Risk of Homelessness Stably Housed Refused

PRIMARY REASON FOR HOMELESSNESS
 Child Abuse/Neglect Dual Diagnosos Mental Illness Runaway Unemployment
 Chronic Alcoholism Eviction Natural Disaster Substance Abuse Underemployment
 Disability HIV/AIDS Release from Prison Transient Victim of Domestic Violence
 NOT HOMELESS

IS CLIENT HOMELESS DUE TO FORECLOSURE? Yes No Don't Know Refused

1st box= TYPE OF LIVING SITUATION-HUD (if public institution and less than 30 days, select where client stayed before that)

2nd box= WHERE CLIENT STAYED THE NIGHT BEFORE COMING TO YOU

Emergency shelter or hotel/motel w/ voucher Perm supp housing for formerly hmls (SHP,S+C,SRO) Substance abuse facility or detox ctr
 Foster care or foster care group home Place not meant for habitation (e.g. vehicle or outside) Transitional housing for homeless
 Hospital (non-psychiatric) Psychiatric hospital or facility With family, temporarily
 Hotel or motel without voucher Rental by client, no housing subsidy With friends, temporarily
 Jail, prison, or juvenile detention facility Rental by client, with other (non-VASH) subsidy Don't Know
 Owned by client, no housing subsidy Rental by client, VASH subsidy Other
 Owned by client, with housing subsidy Safe Haven Refused

LENGTH OF STAY IN LIVING SITUATION-HUD
 One week or less One to three months One year or longer Refused
 More than one week, but less than one month More than three months, but less than one year Don't Know

ZIP CODE OF LAST/CURRENT PERMANENT ADDRESS _____
ZIP CODE DATA QUALITY Full Zip Code Recorded Don't Know Refused

HIGHEST LEVEL OF EDUCATION ATTAINED
 None Nursery-4th grade 5th-6th 7th-8th 9th 10th 11th
 12th, no diploma High school diploma GED Post-secondary Assoc. degree/2yr college
 Technical school Some college Undergraduate college degree Graduate degree
 Post graduate Don't Know Refused

DOES CLIENT HAVE A DISABILITY OF LONG DURATION? Yes No Don't Know Refused (Use same answer for DISABILITY DETERMINATION)

TYPE OF DISABILITY START DATE OF DISABILITY (on or before the program entry) _____

Check 1st box if they have the disability / Check the 2nd box if CURRENTLY RECEIVING SERVICES TREATMENT = Yes

<input type="checkbox"/>	Alcohol Abuse
<input type="checkbox"/>	Both alcohol & drug abuse
<input type="checkbox"/>	Chronic Health Condition
<input type="checkbox"/>	Developmental Disability
<input type="checkbox"/>	Drug Abuse
<input type="checkbox"/>	HIV/AIDS

<input type="checkbox"/>	Mental Health Problem
<input type="checkbox"/>	Physical/Medical
<input type="checkbox"/>	Physical
<input type="checkbox"/>	Hearing Impaired
<input type="checkbox"/>	Other
<input type="checkbox"/>	Other: Alzheimers/Dementia

<input type="checkbox"/>	Other: Cognitive
<input type="checkbox"/>	Other: Learning
<input type="checkbox"/>	Other: Mental Handicap/Injury
<input type="checkbox"/>	Other: Speech
<input type="checkbox"/>	Vision Impaired

SUBSTANCE OF CHOICE _____

MONTHLY INCOME AND BENEFITS (collect at program entry and at exit, also collect one each year if enrollment exceed 1 yr)

Enter separate HMIS subassessment record for each source

INCOME RECEIVED FROM ANY SOURCE IN PAST 30 DAYS Yes No Don't Know Refused

Start Date should be on or around the date they 1st received it

Total Monthly Income \$ _____

Check the box if RECEIVING INCOME SOURCE = Yes

<input type="checkbox"/> \$ _____	Date _____	Alimony or Other Spousal Support (HUD)	<input type="checkbox"/> \$ _____	Date _____	Child Support (HUD)	<input type="checkbox"/> \$ _____	Date _____	Earned inc. (HUD)
<input type="checkbox"/> \$ _____	Date _____	General Assistance (HUD)	<input type="checkbox"/> \$ _____	Date _____	Pension From a Former Job (HUD)	<input type="checkbox"/> \$ _____	Date _____	Prv. Disability Insurance (HUD)
<input type="checkbox"/> \$ _____	Date _____	Retirement Income from Soc. Security (HUD)	<input type="checkbox"/> \$ _____	Date _____	SSDI (HUD)	<input type="checkbox"/> \$ _____	Date _____	SSI (HUD)
<input type="checkbox"/> \$ _____	Date _____	TANF (HUD)	<input type="checkbox"/> \$ _____	Date _____	Unemployment Insur. (HUD)	<input type="checkbox"/> \$ _____	Date _____	Vet's Disability(HUD)
<input type="checkbox"/> \$ _____	Date _____	Veteran's Pension (HUD)	<input type="checkbox"/> \$ _____	Date _____	Worker's Comp. (HUD)	<input type="checkbox"/> \$ _____	Date _____	No financial resources (HUD)
<input type="checkbox"/> \$ _____	Date _____	Other (HUD) Support (HUD)	<input type="checkbox"/> \$ _____	Date _____	Annuities	<input type="checkbox"/> \$ _____	Date _____	Contributions from other people
<input type="checkbox"/> \$ _____	Date _____	Dividends(Investments)	<input type="checkbox"/> \$ _____	Date _____	Interest(bank)	<input type="checkbox"/> \$ _____	Date _____	Railroad Retirement
<input type="checkbox"/> \$ _____	Date _____	Rental Income	<input type="checkbox"/> \$ _____	Date _____	State Disability			

MONTHLY NON-CASH BENEFITS (collect at program entry and at exit, also collect one each year if enrollment exceed 1 yr)

Enter separate subassessment record for each source

ASSISTANCE RECEIVED FROM ANY SOURCE IN PAST 30 DAYS Yes No Don't Know Refused

Start Date should be on or around the date they 1st received it

Amount can be left blank

\$ _____	Date _____	Food Stamps	\$ _____	Date _____	MEDICAID	\$ _____	Date _____	MEDICARE
\$ _____	Date _____	SCHIP	\$ _____	Date _____	Special Supplemental Nutrition Program for WIC	\$ _____	Date _____	VA Medical
\$ _____	Date _____	TANF Child Care Services	\$ _____	Date _____	TANF Transportation	\$ _____	Date _____	Other TANF serv.
\$ _____	Date _____	Section 8 Public Housing or rental assistance	\$ _____	Date _____	Other	Define _____		

IS CLIENT AN EX-OFFENDER Yes No

Needs/Services and Case Notes

NEXT MEETING DATE WITH CLIENT _____

FIRST NAME _____ MI _____ LAST NAME _____ SUFFIX _____

HMIS Program Exit

ENROLLMENT START DATE _____ NAME OF PROGRAM _____

ENROLLMENT END DATE _____

REASON FOR LEAVING PROGRAM

- | | |
|----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Emergency Assistance (not a HUD answer)
PROJECT HOMELESS CONNECT | <input type="checkbox"/> No longer qualifies for program |
| <input type="checkbox"/> Completed program | <input type="checkbox"/> Non-compliance with program |
| <input type="checkbox"/> Criminal activity / violence | <input checked="" type="checkbox"/> Non-payment of rent |
| <input type="checkbox"/> Death | <input type="checkbox"/> Other |
| <input type="checkbox"/> Disagreement with rules/persons | <input type="checkbox"/> Reached maximum time allowed |
| <input type="checkbox"/> Left for housing opp. before completing program | <input type="checkbox"/> Unknown/Disappeared |
| <input type="checkbox"/> Needs could not be met | <input checked="" type="checkbox"/> z-Emergency Shelter (SAHP) |
| | <input checked="" type="checkbox"/> z-Left before completing program (not a HUD answer) |

DESTINATION

- | | | |
|-----------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Deceased | <input type="checkbox"/> Perm supp hsg for formerly hmils (SHP,S+C,SRO) | <input type="checkbox"/> Transitional housing for homeless |
| <input type="checkbox"/> Emergency shltr or hotel/motel w/ voucher | <input type="checkbox"/> Place not meant for habitation (vehicle, outside) | <input type="checkbox"/> With Family, Permanent |
| <input type="checkbox"/> Foster care or foster care group home | <input type="checkbox"/> Psychiatric hospital or facility | <input type="checkbox"/> With Friends, Permanent |
| <input type="checkbox"/> Hospital (non-psychiatric) | <input type="checkbox"/> Rental by client, no housing subsidy | <input type="checkbox"/> With family, temporarily |
| <input type="checkbox"/> Hotel or motel without voucher | <input type="checkbox"/> Rental by client, with other (non-VASH) subsidy | <input type="checkbox"/> With friends, temporarily |
| <input type="checkbox"/> Jail, prison, or juvenile detention facility | <input type="checkbox"/> Rental by client, VASH subsidy | <input type="checkbox"/> Don't Know |
| <input type="checkbox"/> Owned by client, no housing subsidy | <input type="checkbox"/> Safe Haven | <input type="checkbox"/> Other |
| <input type="checkbox"/> Owned by client, with housing subsidy | <input type="checkbox"/> Substance abuse facility or detox ctr | <input type="checkbox"/> Refused |

EMPLOYMENT STATUS

- | | | |
|---------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------|
| <input type="checkbox"/> Full time, NOT looking for addtl hrs | <input type="checkbox"/> Part time, NOT looking for addtl hrs | <input type="checkbox"/> Other |
| <input type="checkbox"/> Full time, looking for addtl hrs | <input type="checkbox"/> Retired | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Part time, looking for addtl hrs | <input type="checkbox"/> Unemployed | <input type="checkbox"/> Refused |

Income and Support (enter income and support information in the file of the client who receives the check/support)

MONTHLY INCOME AND BENEFITS (enter any changes in income)

Enter separate HMIS subassessment record for each source

INCOME RECEIVED FROM ANY SOURCE IN PAST 30 DAYS Yes No Don't Know Refused

Start Date should be on or around the date they 1st received it

Check the box if RECEIVING INCOME SOURCE = Yes

- | | | |
|-----------------------------------------------------------------------------------------|------------------------------------------------------------------------------|------------------------------------------------------------------------------|
| <input type="checkbox"/> \$ _____ Date _____ Alimony or Other Spousal Support (HUD) | <input type="checkbox"/> \$ _____ Date _____ Child Support (HUD) | <input type="checkbox"/> \$ _____ Date _____ Earned inc. (HUD) |
| <input type="checkbox"/> \$ _____ Date _____ General Assistance (HUD) | <input type="checkbox"/> \$ _____ Date _____ Pension From a Former Job (HUD) | <input type="checkbox"/> \$ _____ Date _____ Prv. Disability Insurance (HUD) |
| <input type="checkbox"/> \$ _____ Date _____ Retirement Income from Soc. Security (HUD) | <input type="checkbox"/> \$ _____ Date _____ SSDI (HUD) | <input type="checkbox"/> \$ _____ Date _____ SSI (HUD) |
| <input type="checkbox"/> \$ _____ Date _____ TANF (HUD) | <input type="checkbox"/> \$ _____ Date _____ Unemployment Insur. (HUD) | <input type="checkbox"/> \$ _____ Date _____ Vet's Disability(HUD) |
| <input type="checkbox"/> \$ _____ Date _____ Veteran's Pension (HUD) | <input type="checkbox"/> \$ _____ Date _____ Worker's Comp. (HUD) | <input type="checkbox"/> \$ _____ Date _____ No financial resources (HUD) |
| <input type="checkbox"/> \$ _____ Date _____ Other (HUD) Support (HUD) | <input type="checkbox"/> \$ _____ Date _____ Annuities | <input type="checkbox"/> \$ _____ Date _____ Contributions from other people |
| <input type="checkbox"/> \$ _____ Date _____ Dividends(Investments) | <input type="checkbox"/> \$ _____ Date _____ Interest(bank) | <input type="checkbox"/> \$ _____ Date _____ Railroad Retirement |
| <input type="checkbox"/> \$ _____ Date _____ Rental Income | <input type="checkbox"/> \$ _____ Date _____ State Disability | |

MONTHLY NON-CASH BENEFITS (enter any changes in support)

Enter separate subassessment record for each source

ASSISTANCE RECEIVED FROM ANY SOURCE IN PAST 30 DAYS Yes No Don't Know Refused

Start Date should be on or around the date they 1st received it

Amount can be left blank

- | | | |
|--------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> \$ _____ Date _____ Food Stamps | <input type="checkbox"/> \$ _____ Date _____ MEDICAID | <input type="checkbox"/> \$ _____ Date _____ MEDICARE |
| <input type="checkbox"/> \$ _____ Date _____ SCHIP | <input type="checkbox"/> \$ _____ Date _____ Special Supplemental Nutrition Program for WIC | |
| <input type="checkbox"/> \$ _____ Date _____ Veteran's Admin Medical Services | <input type="checkbox"/> \$ _____ Date _____ TANF Child Care Services | |
| <input type="checkbox"/> \$ _____ Date _____ TANF Transportation | <input type="checkbox"/> \$ _____ Date _____ Other TANF Services | |
| <input type="checkbox"/> \$ _____ Date _____ Section 8 Public Housing or rental assistance | <input type="checkbox"/> \$ _____ Date _____ Other Define | |