

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 F-M Transgender M-F Unknown Don't Know Refused

ETHNICITY Hispanic/Latino Not Hispanic/Latino Don't Know Refused

RACE (1st box=Primary 2nd box=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 LAST PERMANENT RESIDENCE _____ CITY OF LAST PERMANENT RESIDENCE _____ STATE OF LAST PERMANENT RESIDENCE _____

Household Information (do not complete if single individual/household of 1)

Household Type (Single Parent, Couple, etc) _____ *Complete Additional Household Member Intake if there are other members or if the member has income of their own*
 Relationship of this person to the Head of Household (Self, husband, daughter, etc) _____

FIRST NAME _____ MI _____ LAST NAME _____ SUFFIX _____

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

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

ETHNICITY Hispanic/Latino Not Hispanic/Latino Don't Know Refused

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

US MILITARY VETERAN Yes No Don't Know Refused

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

DOES CLIENT HAVE A DISABILITY OF LONG DURATION? Yes No Don't Know Refused

If this household enrolls in an HPRP program, you will need to enter any income or non-cash benefits that this individual receives in their own HMIS file.

NOTE: Enter Consent in the ROI button before going to Entry/Exit

HMIS HPRP Program Enrollment Information (Once you determine eligibility, delete the program enrollment if the client is not eligible)

ENROLLMENT START DATE _____ NAME OF PROGRAM _____

NOTE: If paying back rent/utilities Enrollment Start Date should be the first month covered, not the eligibility determination date.

HOUSING STATUS Literally Homeless Housed & At Risk of Losing Housing Don't Know
 Housed & At Imminent Risk of Losing Housing Stably Housed Refused

ANNUAL HOUSEHOLD INCOME \$ _____ % of Area Median Income _____ %

SUPPORT Does client have enough support/options to avoid homelessness? Yes No Don't Know Refused

BARRIERS Select Housing Barriers Level Level 1 Level 2 Level 3 Level 4 Level 5

(See Optional HPRP Additional Information Assessment in HMIS)

of people in the household (do not include roommates)

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 *Select No if client is not Literally Homeless*

CLIENT CHRONICALLY HOMELESS Yes No *Select No if client is not Literally Homeless and Chronically Homeless*

IS JUVENILE PARENT Yes No Don't Know Refused

PRIMARY REASON FOR HOMELESSNESS (or potential 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 (or will become homeless) DUE TO FORECLOSURE? Yes No Don't Know Refused

1st box=TYPE OF LIVING SITUATION-HUD (if public insitiution and less than 90 days, select where client stayed before that)

2nd box=WHERE CLIENT STAYED THE NIGHT BEFORE COMING TO YOU - this will probably be the same answer as Living Situation-HUD

- | | | |
|---|--|--|
| <input type="checkbox"/> Deceased | <input type="checkbox"/> Perm supp hsg for formerly hmls (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 |

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 coll. Technical school

Some college Undergraduate 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"/> Mental Health Problem | <input type="checkbox"/> Other: Cognitive |
| <input type="checkbox"/> Both alcohol & drug abuse | <input type="checkbox"/> Physical/Medical | <input type="checkbox"/> Other: Learning |
| <input type="checkbox"/> Chonic Health Condition | <input type="checkbox"/> Physical | <input type="checkbox"/> Other: Mental Handicap/Injury |
| <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Other: Speech |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Other | <input type="checkbox"/> Vision Impaired |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Other: Alzheimers/Dementia | <input type="checkbox"/> SUBSTANCE OF CHOICE _____ |

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

MONTHLY INCOME AND BENEFITS (collect at program entry, review every 3 months, review at program exit)

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

- | Date | Date | Date |
|---|--|---|
| <input type="checkbox"/> \$ _____ Earned Income | <input type="checkbox"/> \$ _____ Unemployment Insurance | <input type="checkbox"/> \$ _____ SSI |
| <input type="checkbox"/> \$ _____ SSDI | <input type="checkbox"/> \$ _____ Veteran's Disability Payment | |
| <input type="checkbox"/> \$ _____ Prv. Disability Insurance | <input type="checkbox"/> \$ _____ Worker's Compensation | <input type="checkbox"/> \$ _____ TANF |
| <input type="checkbox"/> \$ _____ General Assistance | <input type="checkbox"/> \$ _____ Retirement Income from Soc Sec | |
| <input type="checkbox"/> \$ _____ Pension From a Frmr Job | <input type="checkbox"/> \$ _____ Veteran's Pension | <input type="checkbox"/> \$ _____ Child Support |
| <input type="checkbox"/> \$ _____ Alimony or Other Spousal Spt. | | |
| <input type="checkbox"/> \$ _____ Contributions from Other People | | <input type="checkbox"/> \$ _____ Annuities |

INCOME CONTINUED ON NEXT PAGE ...

Client ID # _____

Consent Expiration Date _____

INCOME ... (CONT)

\$ _____ Other \$ _____ Railroad Retirement \$ _____ Rental Income

\$ _____ Dividends(Investments) \$ _____ 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

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

IF THERE IS A HOUSEHOLD

Click on Add Household Data button at the top of the program Entry screen.

Check next to the other household members names.

If the main client is a veteran but the other household members are not, change the veteran answers to No.

If the main client is disabled but the other household members are not, change the disability answer to No.

Click on Save and Close

If you changed the veteran OR disability answers to No, change them back while you are on the main client's Entry screen.

Head of Household Information (from HPRP Intake-Enrollment form)

FIRST NAME _____ MI _____ LAST NAME _____ SUFFIX _____

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

Relationship of this person to the Head of Household (husband, daughter, etc) _____

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 Unknown Don't Know Refused

ETHNICITY Hispanic/Latino Not Hispanic/Latino Don't Know Refused

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

US MILITARY VETERAN Yes No Don't Know Refused

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

ZIP CODE OF LAST/CURRENT PERMANENT ADDRESS _____

ZIP CODE DATA QUALITY Full Zip Code Recorded 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"/>	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Problem	<input type="checkbox"/>	<input type="checkbox"/>	Other: Cognitive
<input type="checkbox"/>	<input type="checkbox"/>	Both alcohol & drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	Physical/Medical	<input type="checkbox"/>	<input type="checkbox"/>	Other: Learning
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Health Condition	<input type="checkbox"/>	<input type="checkbox"/>	Physical	<input type="checkbox"/>	<input type="checkbox"/>	Other: Mental Handicap/Injury
<input type="checkbox"/>	<input type="checkbox"/>	Developmental Disability	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impaired	<input type="checkbox"/>	<input type="checkbox"/>	Other: Speech
<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	Vision Impaired
<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Other: Alzheimers/Dementia	SUBSTANCE OF CHOICE _____		

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

MONTHLY INCOME AND BENEFITS (collect at program entry, review every 3 months, review at program exit)

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

Date	Date	Date
<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____
_____ Earned Income	_____ Unemployment Insurance	_____ SSI
<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	
_____ SSDI	_____ Veteran's Disability Payment	
<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____
_____ Prv. Disability Insurance	_____ Worker's Compensation	_____ TANF
<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	
_____ General Assistance	_____ Retirement Income from Soc Sec	
<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____
_____ Pension From a Frmr Job	_____ Veteran's Pension	_____ Child Support
<input type="checkbox"/> \$ _____		
_____ Alimony or Other Spousal Spt.		
<input type="checkbox"/> \$ _____		<input type="checkbox"/> \$ _____
_____ Contributions from Other People		_____ Annuities
<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____
_____ Other	_____ Railroad Retirement	_____ Rental Income
<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	
_____ Dividends(Investments)	_____ State Disability	

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

Carolina Homeless Information Network

Client ID # _____

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

Consent Expiration Date _____

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

IF THERE IS A HOUSEHOLD

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Check next to the other household members names.

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If the main client is disabled but the other household members are not, change the disability answer to No.

Click on Save and Close

If you changed the veteran OR disability answers to No, change them back while you are on the main client's Entry screen.

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

FIRST NAME _____ MI _____ LAST NAME _____ SUFFIX _____

SSN _____
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GENDER Male Female Transgender F-M Transgender M-F Unknown Don't Know Refused

ETHNICITY Hispanic/Latino Not Hispanic/Latino Don't Know Refused

RACE (1st box=Primary 2nd box=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 LAST PERMANENT RESIDENCE _____ CITY OF LAST PERMANENT RESIDENCE _____ STATE OF LAST PERMANENT RESIDENCE _____

Household Information (do not complete if single individual/household of 1)

Household Type (Single Parent, Couple, etc) _____ *Complete Additional Household Member Intake if there are other members or if the member has income of their own*
Relationship of this person to the Head of Household (Self, husband, daughter, etc) _____

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 F-M Transgender M-F Unknown Don't Know Refused

ETHNICITY Hispanic/Latino Not Hispanic/Latino Don't Know Refused

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

US MILITARY VETERAN Yes No Don't Know Refused

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

DOES CLIENT HAVE A DISABILITY OF LONG DURATION? Yes No Don't Know Refused

If this household enrolls in an HPRP program, you will need to enter any income or non-cash benefits that this individual receives in their own HMIS file.

NOTE: If the consent has expired, obtain and enter the new consent using the ROI button

HPRP Recertification - recertify the head of household 3 months after the Entry Date and every 3 months until they exit the program

RECERTIFICATION DATE _____

HOUSING STATUS Stably Housed with HPRP assistance Stably Housed without HPRP assistance

ANNUAL HOUSEHOLD INCOME \$ _____ % of Area Median Income _____ %

SUPPORT Does client have enough support/options to avoid homelessness? Yes No Don't Know Refused

BARRIERS Select Housing Barriers Level Level 1 Level 2 Level 3 Level 4 Level 5

Does client still qualify for HPRP Yes No

Carolina Homeless Information Network

Client ID # _____

www.nhomeless.org * support@nhomeless.org * 877-703-3176
HMIS Services HPRP VERSION

Consent Expiration Date _____

FIRST NAME	MI	LAST NAME	SUFFIX
HPRP Services		Start Date (should be the date the service or assistance was given to the client)	

*In Service Transactions, Source 1 and Source 2 options should indicate which funding stream paid for the cost of the service and time spent.
HPRP1=State HPRP funds HPRP 2=Entitlement Community HPRP funds HPRP 3=Other funds*

FINANCIAL ASSISTANCE

- | | |
|---|--|
| <input type="checkbox"/> Short-term rental assistance (1-3 months)
of Units=1 | Cost of Service=Amount provided this visit \$ _____
Unit Type=short term rent (enter a new service each month) |
| <input type="checkbox"/> Medium-term rental assistance (4-18 months)
of Units=1 | Cost of Service=Amount provided this visit \$ _____
Unit Type=medium term rent (enter a new service each month) |
| <input type="checkbox"/> Rent Assistance - Rent Arrears (back rent)

of Units=# of months back rent _____ | Cost of Service=Amount provided this visit \$ _____

Unit Type=# of months back rent payments |
| <input type="checkbox"/> Security deposit
of Units=1 | Cost of Service=Amount provided this visit \$ _____
Unit Type=single service |
| <input type="checkbox"/> Utility deposit
of Units=1 | Cost of Service=Amount provided this visit \$ _____
Unit Type=single service |
| <input type="checkbox"/> Utility payment
of Units=1 | Cost of Service=Amount provided this visit \$ _____
Unit Type=single service |
| <input type="checkbox"/> Utility Payment - Utility Arrears (back utility)

of Units=# of months back utility payments _____ | Cost of Service=Amount provided this visit \$ _____

Unit Type=# of months back utilities payments |
| <input type="checkbox"/> Moving cost assistance
of Units=1 | Cost of Service=Amount provided this visit \$ _____
Unit Type=single service |
| <input type="checkbox"/> Motel/hotel voucher (when rental unit is identified)
of Units=1 | Cost of Service=Amount provided this visit \$ _____
Unit Type=single service |

HOUSING RELOCATION AND STABILIZATION

- | | | |
|---|-------------------------------|----------------------|
| <input type="checkbox"/> Case Management | # of Units=# of minutes _____ | Unit Type=15 minutes |
| <input type="checkbox"/> Outreach and Engagement | # of Units=# of minutes _____ | Unit Type=15 minutes |
| <input type="checkbox"/> Housing Search and Placement | # of Units=# of minutes _____ | Unit Type=15 minutes |
| <input type="checkbox"/> Legal Services | # of Units=# of minutes _____ | Unit Type=15 minutes |
| <input type="checkbox"/> Credit Repair | # of Units=# of minutes _____ | Unit Type=15 minutes |

CASE NOTES / GOALS

FIRST NAME _____ MI _____ LAST NAME _____ SUFFIX _____

HPRP Program Exit

ENROLLMENT START DATE _____ NAME OF PROGRAM _____

ENROLLMENT END DATE _____

REASON FOR LEAVING PROGRAM

- Emergency Assistance (not a HUD answer)
PROJECT HOMELESS CONNECT
- Completed program
- Criminal activity / violence
- Death
- Disagreement with rules/persons
- Left for housing opp. before completing program
- Needs could not be met

- No longer qualifies for program
- Non-compliance with program
- Non-payment of rent
- Other
- Reached maximum time allowed
- Unknown/Disappeared
- z-Emergency Shelter (SAHP)
- z-Left before completing program (not a HUD answer)

DESTINATION

- Deceased
- Emergency shltr or hotel/motel w/ voucher
- Foster care or foster care group home
- Hospital (non-psychiatric)
- Hotel or motel without voucher
- Jail, prison, or juvenile detention facility
- Owned by client, no housing subsidy
- Owned by client, with housing subsidy

- Perm supp hsg for formerly hmIs (SHP,S+C,SRO)
- Place not meant for habitation (vehicle, outside)
- Psychiatric hospital or facility
- Rental by client, no housing subsidy
- Rental by client, with other (non-VASH) subsidy
- Rental by client, VASH subsidy
- Safe Haven
- Substance abuse facility or detox ctr

- Transitional housing for homeless
- With Family, Permanent
- With Friends, Permanent
- With family, temporarily
- With friends, temporarily
- Don't Know
- Other
- Refused

If client is exiting because of time limits for the program (18 mo for HPRP), does client have a transition plan?

- Yes
- No
- Don't Know
- Refused

Explain the transition plan

EMPLOYMENT STATUS

- Full time, NOT looking for addt'l hrs
- Full time, looking for addt'l hrs
- Part time, looking for addt'l hrs

- Part time, NOT looking for addt'l hrs
- Retired
- Unemployed

- Other
- Don't know
- 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 _____ Earned Income	<input type="checkbox"/> \$ _____ Date _____ Unemployment Insurance	<input type="checkbox"/> \$ _____ Date _____ SSI
<input type="checkbox"/> \$ _____ SSDI	<input type="checkbox"/> \$ _____ Veteran's Disability Payment	
<input type="checkbox"/> \$ _____ Prv. Disability Insurance	<input type="checkbox"/> \$ _____ Worker's Compensation	<input type="checkbox"/> \$ _____ TANF
<input type="checkbox"/> \$ _____ General Assistance	<input type="checkbox"/> \$ _____ Retirement Income from Soc Sec	
<input type="checkbox"/> \$ _____ Pension From a Frmr Job	<input type="checkbox"/> \$ _____ Veteran's Pension	<input type="checkbox"/> \$ _____ Child Support
<input type="checkbox"/> \$ _____ Alimony or Other Spousal Spt.		
<input type="checkbox"/> \$ _____ Contributions from Other People		<input type="checkbox"/> \$ _____ Annuities
<input type="checkbox"/> \$ _____ Other	<input type="checkbox"/> \$ _____ Railroad Retirement	<input type="checkbox"/> \$ _____ Rental Income
<input type="checkbox"/> \$ _____ Dividends(Investments)	<input type="checkbox"/> \$ _____ 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"/> \$ _____ SCHIP	<input type="checkbox"/> \$ _____ Special Supplemental Nutrition Program for WIC	
<input type="checkbox"/> \$ _____ Veteran's Admin Medical Services	<input type="checkbox"/> \$ _____ TANF Child Care Services	
<input type="checkbox"/> \$ _____ TANF Transportation	<input type="checkbox"/> \$ _____ Other TANF Services	
<input type="checkbox"/> \$ _____ Section 8 Public Housing or rental assistance	<input type="checkbox"/> \$ _____ Other	Define _____