

**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  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  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** (complete this section ONLY if the client qualifies for HPRP)

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

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)

- |  |   |  |  |  |
|--|---|--|--|--|
| <input type="checkbox"/> Child Abuse/Neglect | <input type="checkbox"/> Dual Diagnosos | <input type="checkbox"/> Mental Illness      | <input type="checkbox"/> Runaway         | <input type="checkbox"/> Unemployment                |
| <input type="checkbox"/> Chronic Alcoholism  | <input type="checkbox"/> Eviction       | <input type="checkbox"/> Natural Disaster    | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Underemployment             |
| <input type="checkbox"/> Disability          | <input type="checkbox"/> HIV/AIDS       | <input type="checkbox"/> Release from Prison | <input type="checkbox"/> Transient       | <input type="checkbox"/> Victim of Domestic Violence |
|  |   |  |  | <input type="checkbox"/> NOT HOMELESS                |

IS CLIENT HOMELESS (or will become homeless) DUE TO FORECLOSURE?  Yes  No  Don't Know  Refused

TYPE OF LIVING SITUATION-HUD (if public institution and less than 90 days, select where client stayed before that)

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 hngng 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

- |  |   |   |                                  |
|--|---|---|----------------------------------|
| <input type="checkbox"/> One week or less                            | <input type="checkbox"/> One to three months                            | <input type="checkbox"/> One year or longer | <input type="checkbox"/> Refused |
| <input type="checkbox"/> More than one week, but less than one month | <input type="checkbox"/> More than three months, but less than one year | <input type="checkbox"/> Don't Know         |                                  |

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"/> 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 |  |

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

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

Client ID # \_\_\_\_\_

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

**Carolina Homeless Information Network**

Client ID # \_\_\_\_\_

www.nhomeless.org \* support@nhomeless.org \* 877-703-3176  
Optional HPRP Adtl Information

Consent Expiration Date \_\_\_\_\_

FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_ LAST NAME \_\_\_\_\_ SUFFIX \_\_\_\_\_

**HPRP Additional Information** *(it is a "best practice" to enter as much info in the HMIS as you can)*

Does client have enough support/options to avoid homelessness?  Yes  No  Don't Know  Refused  
 Key details from support interview (other support, type of housing support potentially available, types of other support, assistance needed to access support, etc)

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 \_\_\_\_\_ %

Employment Status  Full Time  Part-time, not looking for adtl work/hrs  Other  
 Full-time, looking for adtl work/hrs  Retired  Don't Know  
 Part-time, looking for adtl work/hrs  Unemployed  Refused

**Risk Factors**

- Eviction within 2 weeks from a private dwelling (including housing provided by family or friends)
- Discharge within 2 weeks from an institution where an individual has resided for at least 180 days
- Residency in housing that has been condemned by housing officials and is no longer meant for human habitation
- 2+ moves within the past year
- Sudden and significant loss of income
- Mental Illness (check if Mental Illness is present)
- Previously Hospitalized for Mental Illness
- Substance Abuse (check if currently using abusing drugs or alcohol)
- Previous eviction from subsidized housing
- Young head of household (Under 25) with child under 2 years of age
- Ex-offender
- Significant physical disabilities & other chronic health issues, incl HIV/AIDS
- Less than 15 % of area median income
- Extremely low income (less than 30% of area median income)
- Foster Care or out-of-home placement as a child
- Recent or repeated traumatic life events
- Domestic violence within past 30 days
- Credit problems that preclude obtaining housing
- Veterans with dishonorable or other-than-honorable discharge
- Severe cost burden (paying more than 50% of income for housing)
- Has/had child involved with welfare system (child protective services)
- Sudden and significant loss of income
- Eviction due to landlord/owner of rental unit experiencing foreclosure
- Sudden and significant increase in utility costs
- High overcrowding (the number of persons exceed health and/or safety standards for the housing unit size)
- Prior Episode of Homeless
- Significant amount of medical debt
- Insufficient Education (check if the applicant has not attained a high school diploma or GED)
- Loss of Benefits (Check if the applicant has lost public benefits, including Section 8 and Public Assistance within the

**Barriers to Getting Housing**

**RENTAL HISTORY**

- Established local history. No evictions, good to fair references.
- Limited or out-of-state. May have 1-2 explainable evictions. May have paid rent late.
- Up to 3 evictions for nonpayment. Prior references fair to poor.
- Up to 5 evictions for non-payment or lease violations. References poor. Deposits kept for damage.
- Extremely poor, multiple evictions, serious damage, complaints.

**CRIMINAL HISTORY**

- None
- No serious history-minor offenses like DUI or misdemeanor
- Some criminal history but none involving drugs or serious crimes against people or property
- Violations may include drug offenses or crimes against people or property
- Extensive criminal background

**CREDIT HISTORY**

- Good-few late utility and credit card payments
- Pattern of late or missed payments
- Poor, late payments, judgement for dept to landlords, closed accounts
- Multiple judgements, unpaid debts to landlords, closed accounts

**Carolina Homeless Information Network**

Client ID # \_\_\_\_\_

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

Consent Expiration Date \_\_\_\_\_

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

*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)<br># of Units=1  | Cost of Service=Amount provided this visit \$ _____<br>Unit Type=short term rent (enter a new service each month)  |
| <input type="checkbox"/> Medium-term rental assistance (4-18 months)<br># of Units=1  | Cost of Service=Amount provided this visit \$ _____<br>Unit Type=medium term rent (enter a new service each month) |
| <input type="checkbox"/> Rent Assistance - Rent Arrears (back rent)<br><br># of Units=# of months back rent _____                   | Cost of Service=Amount provided this visit \$ _____<br><br>Unit Type=# of months back rent payments                |
| <input type="checkbox"/> Security deposit<br># of Units=1   | Cost of Service=Amount provided this visit \$ _____<br>Unit Type=single service                                    |
| <input type="checkbox"/> Utility deposit<br># of Units=1  | Cost of Service=Amount provided this visit \$ _____<br>Unit Type=single service                                    |
| <input type="checkbox"/> Utility payment<br># of Units=1  | Cost of Service=Amount provided this visit \$ _____<br>Unit Type=single service                                    |
| <input type="checkbox"/> Utility Payment - Utility Arrears (back utility)<br><br># of Units=# of months back utility payments _____ | Cost of Service=Amount provided this visit \$ _____<br><br>Unit Type=# of months back utilities payments           |
| <input type="checkbox"/> Moving cost assistance<br># of Units=1   | Cost of Service=Amount provided this visit \$ _____<br>Unit Type=single service                                    |
| <input type="checkbox"/> Motel/hotel voucher (when rental unit is identified)<br># of Units=1                                       | Cost of Service=Amount provided this visit \$ _____<br>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

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

Client ID # \_\_\_\_\_

**Carolina Homeless Information Network**  
www.nhomeless.org \* support@nhomeless.org \* 877-703-3176  
HMIS Exit HPRP VERSION

Consent Expiration Date \_\_\_\_\_

**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"/> \$ _____	<input type="checkbox"/> \$ _____
_____ Contributions from Other People	_____ Railroad Retirement	_____ Annuities
<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____
_____ Other	_____ State Disability	_____ Rental Income
<input type="checkbox"/> \$ _____		
_____ Dividends(Investments)		

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**

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.