Homeless Resource Council of the Sierras HMIS Entry Form – PSH, RRH, TH and HP

Project Entry Date:_____/_____/_____ **Intake Staff Name:** _____

Project Name: _____ **HMIS Client ID** (ServicePoint Generated)**:** _____

First Name		**Client Location**	☐CA-515 (CoC Code for Placer County) ☐CA-531 (CoC Code for Nevada County)
Middle Name		**Name Quality**	☐Full Name ☐Partial, Street Name, or Code Name ☐Client Doesn't Know ☐Client Refused
Last Name			
SS#	_____- _____- _____	**SS Quality**	☐Full SSN ☐Client Doesn't Know ☐Partial SSN ☐Client Refused
Date of Birth	_____/_____/_____	**DOB Type**	☐Full DOB ☐Client Doesn't Know ☐Approximate or Partial DOB ☐Client Refused
Phone Number	( )	**Served "Active Duty" in Armed Forces?**	☐Yes ☐Client Doesn't Know ☐No ☐Client Refused
Email Address		**Gender**	☐Female ☐Male ☐Trans Female (MTF or Male to Female) ☐Trans Male (FTM or Female to Male) ☐Gender Non-Conforming (i.e. not exclusively male or female ☐Client Doesn't Know ☐Client Refused
Address or Current Location			
Zip Code			
Relationship to Head of Household (HoH)	☐Self (Head of Household) ☐HoH's Child ☐HoH's Spouse or Partner ☐HoH's other relation member ☐Other: non-relation member *If not Self, write Head of Household's Name:* _____	**Ethnicity**	☐Hispanic/Latino ☐Non-Hispanic/Latino ☐Client Doesn't Know ☐Client Refused
		Race Check ALL that apply (and circle P to select ONE Primary)	☐American Indian or Alaska Native P ☐Asian P ☐Black or African-American P ☐Native Hawaiian or Pacific Islander P ☐White P ☐Client Doesn't Know ☐Client Refused

Prior Living Situation: ***What Type of Residence was client in just before project start?*** *(Select ONE type of residence. Answer sub-questions.)*

Literally Homeless

☐Place not meant for habitation (e.g. a vehicle, an abandoned building, bus/train/subway station, airport, or anywhere outside)

☐Emergency shelter, including hotel/motel paid for with emergency shelter voucher, or RHY-funded Host Home Shelter

☐Safe Haven

Length of Stay _____ days *Answer CH Questions.*

Institutional Situation

☐Foster care home or foster care group home
☐Hospital or other, non-psychiatric, medical facility
☐Jail, prison, or juvenile detention facility
☐Long term care facility or nursing home
☐Psychiatric hospital or other psychiatric facility
☐Substance abuse treatment facility/detox

Length of Stay _____days *If more than 90 days, skip CH Questions.* *If less than 90 days, ask question below.*

On the night before, did you stay on the streets, in shelter or in safe haven? ☐Yes ☐No *If YES, answer CH Questions.*

Transitional and Permanent Housing Situation

☐Residential project or halfway house with no homeless criteria (ie. sober living with no lease/tenancy rights)
☐Hotel or motel paid for without an emergency voucher
☐Transitional housing for homeless persons (inc. youth)
☐Host home (non-crisis)
☐Staying in family member's room, apartment or house
☐Staying in friend's room, apartment or house
☐Permanent housing (other than RRH) for formerly homeless persons
☐Rental by client, with VASH housing subsidy
☐Rental by client, with RRH or equivalent subsidy
☐Rental by client, with Housing Choice Voucher (HCV)
☐Rental by client, no ongoing housing subsidy
☐Rental by client, with other ongoing housing subsidy
☐Rental by client in a public housing unit
☐Owned by client, no ongoing housing subsidy
☐Owned by client, with ongoing housing subsidy

Length of Stay _____days *If more than 7 days, skip CH Questions.* *If less than 7 days, ask question below.*

On the night before, did you stay on the streets, in shelter or in safe haven? ☐Yes ☐No *If YES, answer CH Questions.*

CH QUESTIONS		
Approximate Date Most Recent Episode of Homelessness Started	_____/_____/_____	
(Regardless of where they stayed last night) Total number of <u>times</u> homeless on the street, in Emergency Shelter, or Safe Haven in the past three years including today	☐1 time ☐2 times ☐3 times	☐4 or more times ☐Client Doesn't Know ☐Client Refused
Total number of <u>months</u> homeless on the street, in Emergency Shelter, or Safe Haven in the past three years	☐One month (this time is the first month) ☐ _____2-12 months (write number) ☐More than 12 months	☐Client Doesn't Know ☐Client Refused

Any Disabling Condition*	☐Yes ☐No ☐Client Doesn't Know ☐Client Refused				For each condition identified, provide an answer (X) below whether that condition is expected to be of long-continued/indefinite duration and substantially impedes ability to live independently.			
Provide answer (X) for <u>each</u> condition below:	**Yes**	**No**	**Client Doesn't Know**	**Client Refused**	**Yes**	**No**	**Client Doesn't Know**	**Client Refused**
Physical Disability	☐	☐	☐	☐	☐	☐	☐	☐
Chronic Health Condition	☐	☐	☐	☐	☐	☐	☐	☐
Mental Health Problem	☐	☐	☐	☐	☐	☐	☐	☐
Substance Abuse Problem	☐Alcohol Abuse ☐Drug Abuse ☐Both Alcohol & Drug Abuse	☐	☐	☐	☐	☐	☐	☐
HIV/AIDS	☐	☐	☐	☐	**Answer YES to 'Any Disabling Condition' if answer above is YES to any condition, or if client has HIV/AIDS or a Developmental Disability or is a veteran with a qualifying injury/illness incurred during active service.*			
Developmental Disability	☐	☐	☐	☐				

Income Received from Any Source?	☐Yes ☐No ☐Client Doesn't Know ☐Client Refused		***Answer Yes or No for ALL sources of income below, and if Yes, provide monthly dollar amount client is receiving.***		
Source of Income	**Receiving?**	**Amount**	**Source of Income**	**Receiving?**	**Amount**
Earned Income	☐Yes ☐No	$.	Temporary Assistance for Needy Families (TANF)	☐Yes ☐No	$.
Unemployment Insurance	☐Yes ☐No	$.	General Assistance (GA)	☐Yes ☐No	$.
Supplemental Security Income (SSI)	☐Yes ☐No	$.	Retirement Income from Social Security	☐Yes ☐No	$.
Social Security Disability Insurance (SSDI)	☐Yes ☐No	$.	Pension/Retirement from a former job	☐Yes ☐No	$.
VA Service – Connected Disability Compensation	☐Yes ☐No	$.	Child Support	☐Yes ☐No	$.
VA Non-Service Connected Disability Pension	☐Yes ☐No	$.	Alimony/Spousal Support	☐Yes ☐No	$.
Private Disability Insurance	☐Yes ☐No	$.	Other: _____		$.
Workers' Compensation	☐Yes ☐No	$.	**Total *Monthly* Income**		$.

Non-Cash Benefits Received?	☐Yes ☐Client Doesn't Know ☐No ☐Client Refused	**Covered by Health Insurance?**	☐Yes ☐Client Doesn't Know ☐No ☐Client Refused

Answer Yes or No to all sources below:			***Answer Yes or No to all sources below:***		
Source of Non-Cash Benefit	**Yes**	**No**	**Source of Health Insurance**	**Yes**	**No**
Supplemental Nutritional Assistance Program (SNAP) (CalFresh or "Food Stamps")	☐	☐	MEDICAID (Medi-Cal)	☐	☐
Special Supplementation Nutritional Program for (WIC)	☐	☐	MEDICARE	☐	☐
TANF Child Care Services	☐	☐	State Children Health Insurance Program	☐	☐
TANF Transportation Services	☐	☐	VA Medical Services	☐	☐
Other TANF-Funded Services	☐	☐	Employer Provided Health Insurance	☐	☐
Other:_____	☐	☐	Health Insurance obtained through COBRA	☐	☐
			Private Pay Health Insurance	☐	☐
			State Health Insurance for Adults	☐	☐
			Indian Health Services Program	☐	☐
			Other:_____	☐	☐

DV/ SA/ HT/ Stalking Victim/Survivor	☐Yes ☐No	☐Client Doesn't Know ☐Client Refused
If yes to DV, when experience occurred	☐Within past three months ☐Three to six months ago ☐Six to twelve months ago	☐More than a year ago ☐Client Doesn't Know ☐Client Refused
If yes to DV, are you currently fleeing?	☐Yes ☐No	☐Client Doesn't Know ☐Client Refused

Permanent Housing Projects (RRH and PSH Only)		
Housing Move-In Date	_____/_____/_____	