Contact colorado.hmis@coloradocoalition.org for any questions regarding documents or collection practices.

HMIS Individual Intake Form (05-10-2016)

(FOR AGENCY USE ONLY)
Program Entry Date: ____/____/______ **Program Name/Grant:** ____

Case Manager: ________________________________

Legal First Name: ________________________________ **Legal Middle Name:** ________________

Legal Last Name: ____ **Suffix:** ______________
Name Data quality: ❑ Full name reported ❑ Partial, street name, or code name reported ❑ Client Doesn't Know ❑ Client Refused

Date of Birth (mm/dd/yyyy): ________/_____/______ ❑ Full ❑ Approximate or Partial ❑Client Doesn't Know ❑ Client Refused

Social Security #: ______ – _____ – ________ ❑ Full ❑ Approximate or Partial ❑Client Doesn't Know/Don't Have ❑ Client Refused

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Tell Us about Your Last Permanent Address *(where you last lived for 90 days or more)*

City______________________County________________ State/Province__________Zip__________

Phone: ________________PH Type: __________Phone Alt: ________________PH Type: __________

Email: ________________________________Contact Preference: ____________________

Are You Homeless? (Housing Status): ❑ Homeless ❑ Imminently losing housing ❑ Homeless under other Federal statutes
❑ Fleeing domestic violence ❑ At risk of losing housing ❑ Stably housed ❑ Client Doesn't Know ❑ Client Refused

Disabling Condition: ❑Yes ❑No ❑ Client Doesn't Know ❑ Client Refused

Educational Level (choose one):			
❑ No Schooling Completed	❑ Nursery to 4th Grade	❑ 5th or 6th Grade	❑ 7th or 8th Grade
❑ 9th Grade	❑ 10th Grade	❑ 11th Grade	❑ 12th Grade, No diploma
❑ High School Diploma	❑ GED	❑ Post-Secondary	❑ 4 year College
❑ Graduate School	❑ Client Doesn't Know	❑ Client Refused	❑ Unknown

Relationship to HoH: ❑ Child ❑ Step Child ❑ Grand Child ❑ Head of household's other relation member ❑ Other (non-relation member)

Military Background (Served/Serving in US Miltary): ❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused

Gender: ❑ Male ❑ Female ❑ Transgender Male to Female ❑ Transgender Female to Male
❑ Other ____________ ❑ Client Doesn't Know ❑ Client Refused

Ethnicity: ❑ Non-Hispanic/Non-Latino ❑ Hispanic/Latino ❑ Client Doesn't Know ❑ Client Refused

Race (choose all that apply): ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American
❑ Native Hawaiian or Other Pacific Islander ❑ White ❑Client doesn't know ❑ Client Refused

INCOME & BENEFITS

Income Source (*Choose all that applies*) Note: All PAY INTERVALS should be Monthly	Stated Income	Documentation
❑ No Financial Resources		
❑ Earned Income (i.e. employment income)	$_________	
❑ Unemployment Insurance	$_________	
❑ Supplemental Security Income (SSI)	$_________	
❑ Social Security Disability Income (SSDI)	$_________	
❑ Veteran's Service-Connected Disability Compensation	$_________	
❑ Veteran's Non-Service-Connected Disability Compensation	$_________	
❑ Private Disability Insurance	$_________	
❑ Worker's Compensation	$_________	
❑ Temporary Assistance for Needy Families (TANF)	$_________	
❑ General Assistance (GA)	$_________	
❑ Retirement Income from Social Security	$_________	
❑ Pension from Former Job	$_________	
❑ Child Support	$_________	
❑ Alimony/Other Spousal Support	$_________	
❑ Aid to the Needy and Disabled (AND)	$_________	
❑ Old Age Pension (OAP)	$_________	
❑ Other Sources	$_________	
❑ Client Doesn't Know ❑ Client Refused		

Non-Cash Benefits (*Choose all that applies*)

❑ None ❑ Client Doesn't Know ❑ Client Refused ❑ Other Benefit Source:_________________
❑ Food Stamps/SNAP $___________ (amount optional) ❑ TANF Child Care ❑ Temporary Rental Assistance
❑ TANF Transportation Services ❑ Section 8 or Rental Assistance
❑ WIC (Women, Infants and Children) ❑ Other TANF-funded Services

HEALTH INSURANCE

❑ No Health Insurance ❑ Client Doesn't Know ❑ Client Refused ❑ Other_________________
❑ MEDICAID ❑ MEDICARE ❑ State Childen's Health Insurance ❑ Veteran's - VA Medical Services
❑ Employer provided Health Insurance ❑ COBRA ❑ Private Pay Health Insurance ❑ State Adult Health Insurance

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Family Contact Tab: What is the Client's Current Address? (*Click "Is Mailing Address" if you are recording the current address in this tab*),

Address:____City:__________________

County:______________________ State:___________________Zip:____________________

Phone: ______________________________PH Type: _________

Email: ____Contact Preference:_________________________

Program Entry

Prior Living Situation (Where did you stay last night - *choose one)*:	
❑ Emergency Shelter, including hotel/motel paid for with emergency shelter voucher	❑ Rental by Client with VASH Housing Subsidy
❑Foster care home or forest care group home	❑ Rental by Client, with GPD TIP subsidy
❑ Hospital or other residential non-Psychiatric facility	❑ Rental by Client, with other ongoing housing subsidy
❑ Hotel or Motel Paid for without an Emergency Shelter Voucher	❑Residential project of halfway house with no homeless criteria
❑ Jail, Prison or Other Juvenile Facility	❑ Safe Haven
❑ Long-term Care Facility or nursing home	❑ Staying or Living in a **Family** Member's Room, Apartment or House
❑ Owned by Client, No Housing Subsidy	❑ Staying or Living in a **Friend's** Room, Apartment, or House
❑ Owned by Client, With Housing Subsidy	❑ Substance Abuse Treatment Facility or Detox Center
❑ Permanent Housing for Formerly Homeless Persons	❑ Transitional Housing for Homeless Persons
❑ Place Not Meant for Habitation (Car or Other Vehicle, Abandoned Building, Bus/Train/Subway Station/ Airport, Street or Camping)	❑ Other ______________________________
❑ Psychiatric Hospital or other Psychiatric Facility	❑ Client Doesn't Know
❑ Rental by Client, No Housing Subsidy	❑ Client Refused

Length of Stay in Previous Place? *(choose one)*:

❑ One Day or Less ❑ Two Days to one week ❑ More than 1 week, less than 1 month ❑ 1 month to 3 months
❑ 1 year or longer ❑ More than three months but less than one year

Program Entry Questions

Client entering from the streets, shelter or safe haven ❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused

Approximate Date Started? _____________

Number of times the client has been homeless on the streets, in ES or Safe haven in the past three years *(INCLUDING today*- *choose one***)**:
❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 or More ❑ Client Doesn't Know ❑ Client Refused

Total number of months homeless on the streets, in ES or Safe haven in the past three years? (*INCLUDING THIS TIME* *- choose one and please write specific number):* ❑ 0-12 _____________❑ 12+ _____________ ❑ Client Doesn't Know ❑ Client Refused

If you're prior living situation was Hospital, other residential non-psychiatric facility, Jail, Prison, Juvenile Facility, Substance Abuse Treatment Facility, or Detox Center did you come from an Emergency Shelter or, Place Not Meant for Habitation? ❑ Yes ❑ No ❑ N/A

Reasons or Contributing Factors to Homeless Situation *(choose all that apply)*:

❑ Abuse or violence in my home
❑ Alcohol/substance abuse problems
❑ Asked to leave
❑ Bad credit
❑ Couldn't pay utilities
❑ Discharge from foster care
❑ Discharged from jail
❑ Discharged from prison
❑ Family member or personal illness
❑ Legal problems
❑ Medical expenses
❑ Mental illness
❑ Moved to find work
❑ Problems with public benefits
❑ Reasons related to my sexual orientation
❑ Relationship problems or family break-up
❑ Unable to pay rent/mortgage
❑ Other ___________________________
❑ Doesn't apply to me
❑ Lost Job Couldn't find work

Health Information				
Do you have a physical disability?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
If yes, is it expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
If yes, is there documentation of the disability and its severity on file?	❑ Yes	❑ No		
If yes, are you currently receiving services or treatment for this condition?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
Do you have a developmental disability?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
If yes, is it expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
If yes, is there documentation of the disability and its severity on file?	❑ Yes	❑ No		
If yes, are you currently receiving services or treatment for this condition?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
Do you have a chronic health condition?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
If yes, is it expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
If yes, is there documentation of the disability and its severity on file?	❑ Yes	❑ No		
If yes, are you currently receiving services or treatment for this condition?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
Have you been diagnosed with AIDS or have you tested positive for HIV?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
If yes, is it expected to substantially impair your ability to live independently?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
If yes, is there documentation of the disability and its severity on file?	❑ Yes	❑ No		
If yes, are you currently receiving services or treatment for this condition?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
Do you feel that you have a mental health problem?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
If yes, is it expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
If yes, is there documentation of the disability and its severity on file?	❑ Yes	❑ No		
If you have a mental health problem: Are you currently receiving services or treatment for this condition?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
Mental Health: If yes for condition how confirmed?	❑ Unconfirmed; presumptive or self- report	❑ Confirmed through assessment and clinical evaluation	❑ Confirmed by prior evaluation or clinical records	
Mental Health: Serious mental illness (SMI) and if SMI how confirmed.	❑ No	❑ Unconfirmed; presumptive or self- report	❑ Confirmed by prior evaluation or clinical records	❑ Client Doesn't Know ❑ Data not Collected ❑ Client Refused
Do you have a drug or alcohol problem?	❑ Alcohol ❑ Drug ❑ Both	❑ No	Know	❑ Client Refused
If yes, is it expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?	❑ Yes	❑ No	❑ Client Doesn't	❑ Client Refused
If yes, is there documentation of the disability and severity on file?	❑ Yes	❑ No	Know	
If yes, are you currently receiving services or treatment for this condition?	❑ Yes	❑ No	❑ Client Doesn't	❑ Client Refused

DOMESTIC ABUSE

Information Date: _____/_____/_______

Are you a survivor of domestic or intimate partner violence: ❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused

If you experienced domestic or intimate partner violence, how long ago did you have this experience?:

❑ Within the past 3 months ❑ 3 to 6 months ago (excluding 6 months exactly) ❑ 6 to 12 months ago (excluding 12 months exactly)

❑ One year ago or more ❑ Client Doesn't Know ❑ Client Refused

Are you currently fleeing: ❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused

MILITARY

Year entered military service: _____/_____/_______

Year separated from military service: _____/_____/_______

Theater of Operations (Check all that apply):

❑ **Persian Gulf (Operation Desert Storm)**	❑ **Korean War:**
❑ **Iraq (Operation New Dawn)**	❑ **WW II:**
❑ **Iraq (Operation Iraqi Freedom)**	❑ **Other Peace-keeping Operations or Military Interventions (such as Lebanon, Panama, Somalia, Bosnia, Kosovo)**
❑ **Afghanistan (Operation Enduring Freedom)**	❑ **Client Doesn't Know**
❑ **Vietnam Era**	❑ **Client Refused**

What branch of the military did you serve? (Check all that apply):

❑ Army	❑ Air Force	❑ Navy
❑ Marines	❑Coast Guard	❑ Client Doesn't Know ❑ Client Refused

What type of Discharge did you receive? ❑ Honorable ❑ General under honorable conditions ❑ Under other than honorable conditions (OTH) ❑ Bad Conduct ❑ Dishonorable ❑Uncharacterized ❑ Client Doesn't Know ❑ Client Refused

Note: This section is for special programs that require additional question sets.

SSVF QUESTIONS (*Only answer these questions for VA programs)*

Household Income as a Percentage of AMI? ☐ Less than 30% ☐ 30% to 50% ☐ Greater than 50% **VAMC Station Number?**___________________________________

HOPWA QUESTIONS *(Only answer these questions for HOPWA programs)*

Information Date: _____/_____/_______

Receiving Public HIV/AIDS Medical Assistance: ☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused

***Reason (if no)*:** ☐ Applied; decision pending ☐ Applied; client not eligible ☐ Client did not apply ☐ Insurance type N/A for this client ☐ Client doesn't know ☐ Client refused

Receiving AIDS Drug Assistance Program (ADAP): ☐ No ☐ Yes ☐ Client doesn't know ☐ Client refused

***Reason (if no)*:** Applied; decision pending ☐ Applied; client not eligible ☐ Client did not apply ☐ Insurance type N/A for this client

Information Date: _____/_____/_______

T-Cell (CD4) Count Available: ☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused

***Reason (if no)*:** ☐ Applied; decision pending ☐ Applied; client not eligible ☐ Client did not apply ☐ Insurance type N/A for this client ☐ Client doesn't know ☐ Client refused

Receiving AIDS Drug Assistance Program (ADAP): ☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused

***Reason (if no)*:** ☐ Applied; decision pending ☐ Applied; client not eligible ☐ Client did not apply ☐ Insurance type N/A for this client ☐ Client doesn't know ☐ Client refused

RAPID RE-HOUSING (RRH)

Information Date: _______/______/_________ **In Permanent Housing?** ☐ Yes ☐ No
Date of Move-In? (if yes) ___________/____________/_________________

Client Signature: ____ Date: _________________