

# HMIS Intake and Enrollment Form PATH

For persons entering HMIS project type: **PATH**

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

Client DMH #: \_\_\_\_\_

**Program Start Date: (PORI Date)** \_\_\_\_\_

Staff Completing HMIS Form: \_\_\_\_\_

Also for persons entering CES Enrollment (reminder to collect the VISPDAT & Self-Sufficiency)

**Identification** - All fields required unless otherwise noted

BHRS/HMIS ROI Completion Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Last Name \_\_\_\_\_ Suffix \_\_\_\_\_

Name Data Quality: Did the client provide their full name?	Social Security Number (SSN) / Data Quality	Date of Birth (DOB) / Data Quality
<input type="checkbox"/> Full Name Reported <input type="checkbox"/> Partial, street name, or code name reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	_____ - _____ - _____ <input type="checkbox"/> Full SSN reported <input type="checkbox"/> Approximate or partial SSN reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	_____ / _____ / _____ <input type="checkbox"/> Full DOB reported <input type="checkbox"/> Approximate or partial DOB reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

**Basic Demographics** – All fields required unless otherwise noted

**Ethnicity**

**Hispanic/Latino(a)(o)(x)** is a person of Central American, Latin American, or South American origin, separate from race.

**Non-Hispanic/ Non-Latino(a)(o)(x)** is a person NOT of Central American, Latin American, or South American origin, separate from race.

Client Doesn't Know

Client Refused

**Race (Check all that apply)**

**American Indian, Alaska Native, or Indigenous** is a person having origins to any of the indigenous peoples of North and South America, including Central America.

**Asian or Asian American** is a person having origins of Asian descent, including but not limited to Chinese, Indian, Japanese, Korean, Pakistani, Vietnamese, or another representative nation/region.

**Black, African American, or African** is a person having origins to any of the Black racial groups of Africa, including Afro-Caribbean.

**Native Hawaiian or Pacific Islander** is a person having origins in any of the indigenous peoples of Hawaii, Guam, Samoa, or another Pacific Island.

**White** is a person having origins in any of the original peoples of Europe, the Middle East or North Africa.

Client Doesn't Know

Client Refused

**Gender (Check all that apply)** Client authorizes update in HMIS if gender is different?  Yes  No

**Female** is a person who lives or identifies as female.

**Male** is a person who lives or identifies as male.

**A gender other than singularly female or male (e.g., non-binary, genderfluid, agender, culturally specific gender)** is a person who lives or identifies as a gender other than female, a gender other than male, a gender outside the binary, no gender, more than one gender, a culturally specific gender, or a gender that changes over time.

**Transgender** is a person who lives or identifies with a transgender history, experience, or identity.

**Questioning** is a person who may be unsure, may be exploring, or may not relate to or identify with a gender identity at this time.

Client Doesn't Know

Client Refused

**Veteran - Have you ever served in the U.S. Military?**  Yes  No  Client Doesn't Know  Client Refused

**Relationship to Head of Household**  Self  Dependent Child  Other: Non-Family Member  
 Son  Spouse  
 Daughter  Other: Family Member

**Program Enrollment**  
 (Ask the client where he/she stayed last night)

Outreach **Place not meant for habitation (i.e. streets, under bridges, camps, camp grounds, abandoned buildings, buildings meant for animals, vehicles, public areas)**

Supportive Services **(Select this if the client's answer DOES NOT fall under "Place not meant for habitation")**

**Date of Engagement (O/R-Intake completed)** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

<b>Date of PATH Status Determination (POR 3 Date)</b> (SMI confirmed, client homeless/at risk, client agrees to services and IRP completed/signed)	____/____/____
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<b>Client Became Enrolled in PATH (POR3)</b>	<input type="checkbox"/> Yes (Only select when there is a PATH Status Determination Date above) <input type="checkbox"/> No (Select options below) <ul style="list-style-type: none"> <li><input type="checkbox"/> Client was found ineligible for PATH (Confirmed no SMI or client is not homeless/at risk of homelessness)</li> <li><input type="checkbox"/> Client was not enrolled for another reason (i.e. Unable to confirm SMI, client left the program, IRP not yet completed)</li> <li><input type="checkbox"/> Unable to locate client</li> </ul>
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**Universal Data Assessment**

**Living Situation: Identify the type of residence and length of stay at that residence just prior to (i.e., program admission)**

<u><b>Literally Homeless Situations</b></u>		<b>2. Length of stay in prior living situation?</b>	
<b>1. What was the living Situation you were living in immediately prior to project entry?</b>		<input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> One month or more, but less than 90 days <input type="checkbox"/> 90 days or more, but less than one year <input type="checkbox"/> One year or longer <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	
<input type="checkbox"/> Place not meant for habitation ( <b>Street Outreach Project ONLY</b> ) <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher or RHY funded Host Home shelter (i.e. CHSS, Mission, Respite, Rest House) <input type="checkbox"/> Safe Haven			
<b>3. What approximate date did you start living on the streets, emergency shelter, or safe haven? (Approximate date homelessness started)</b>		____/____/____	
<b>4. Regardless of where they stayed last night -- Number of times the client has been on the streets, in ES, or SH in the past three years including today?</b>		<input type="checkbox"/> One Time <input type="checkbox"/> Two Times <input type="checkbox"/> Three Times	<input type="checkbox"/> Four or more times <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
<b>5. Total number of months homeless on the streets, in ES, or SH in the past three years?</b>		<input type="checkbox"/> One Month (this time is the first month) <input type="checkbox"/> 2-12 (____ months)	<input type="checkbox"/> More than 12 <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

<u><b>Institutional Situations</b></u>		<b>2. Did you stay less than 90 Days</b>		<b>3. Length of stay in prior living Situation?</b>	
<b>1. What was the living Situation you were living in immediately prior to project entry?</b>		<input type="checkbox"/> Yes (Continue to questions 3-4) <input type="checkbox"/> No ( Continue to question 3 and then Enter Wellness Assessment)		<input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> One month or more, but less than 90 days <input type="checkbox"/> 90 days or more, but less than one year <input type="checkbox"/> One year or longer <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	
<input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail, prison or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center					
<b>4. On the night before did you stay on the street, Emergency Shelter, or Safe Haven</b>		<input type="checkbox"/> Yes(Continue to questions 5-7) <input type="checkbox"/> Client Doesn't Know		<input type="checkbox"/> No (Continue with Wellness Assessment) <input type="checkbox"/> Client Refused	
<b>5. What approximate date did you start living on the streets, emergency shelter, or safe haven? (Approximate date homelessness started)</b>		____/____/____			

<b>6. Regardless of where they stayed last night Number of times the client has been on the streets, in ES, or SH in the past three years including today?</b>	<input type="checkbox"/> One Time <input type="checkbox"/> Two Times <input type="checkbox"/> Three Times	<input type="checkbox"/> Four or more times <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
<b>7. Total number of months homeless on the streets, in ES, or SH in the past three years?</b>	<input type="checkbox"/> One Month (this time is the first month) <input type="checkbox"/> 2-12 (____ months)	<input type="checkbox"/> More than 12 <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
<u><b>Transitional &amp; Permanent Housing Situations</b></u>		
<b>1. What was the living Situation you were living in immediately prior to project entry?</b>	<b>2. Did you stay less than 7 Nights</b>	<b>3. Length of stay in prior living Situation?</b>
<input type="checkbox"/> Residential project or halfway house with no homeless criteria (i.e. Sober Living) <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Staying or living in a friend's room, apartment or house <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> Rental by client, with GPD TIP subsidy <input type="checkbox"/> Permanent housing (Other than RRH) for formerly homeless persons <input type="checkbox"/> Rental by client, with RRH or equivalent subsidy <input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based) <input type="checkbox"/> Rental by client, in a public housing unit <input type="checkbox"/> Rental by client, no ongoing housing subsidy (i.e. Room & Board) <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes (Continue to questions 3-4) <input type="checkbox"/> No (Answer 3 then continue to Wellness Assessment)	<input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> One month or more, but less than 90 days <input type="checkbox"/> 90 days or more, but less than one year <input type="checkbox"/> One year or longer <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
<b>4. On the night before did you stay on the street, Emergency Shelter, or Safe Haven</b>	<input type="checkbox"/> Yes(Continue to questions 5-7) <input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> No (Continue with Wellness Assessment) <input type="checkbox"/> Client Refused
<b>5. What approximate date did you start living on the streets, emergency shelter, or safe haven? (Approximate date homelessness started)</b>	_____/_____/_____	
<b>6. How many times has the client been homeless on the streets, in shelters in the past 3 years?</b>	<input type="checkbox"/> One Time <input type="checkbox"/> Two Times <input type="checkbox"/> Three Times	<input type="checkbox"/> Four or more times <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
<b>7. Total number of months homeless on the streets, in ES, or SH in the past three years</b>	<input type="checkbox"/> One Month (this time is the first month) <input type="checkbox"/> 2-12 (____ months)	<input type="checkbox"/> More than 12 <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

<b>Health Insurance</b>					
<input type="checkbox"/> Yes (Enter Source (s) Below)		<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	
<b>Health Insurance Sources</b>	<input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> MEDICAID <input type="checkbox"/> State Children's Health Insurance (SCHIP) <input type="checkbox"/> VA Medical Services	<input type="checkbox"/> Employer Provided Health Insurance <input type="checkbox"/> Health Insurance obtained through COBRA <input type="checkbox"/> State Health Insurance Adults (Medi-cal) <input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Other _____			
<b>Connection with SOAR (Is the client connected with BHRS SSI/SSDI staff, PATH O/R staff or other SOAR staff)</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
<b>Alcohol Use Disorder</b>		<input type="checkbox"/> Yes (Answer Questions Below)	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
1. Expected to be of long-continued and indefinite duration and substantially impairs one's ability to live independently?					
<input type="checkbox"/> Yes		<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	
2. Documentation of disability and severity on file? (Staff Answer)					
		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
3. How confirmed? PATH ONLY (Staff Answer)					
<input type="checkbox"/> Unconfirmed; presumptive or self-report		<input type="checkbox"/> Confirmed by prior evaluation or clinical records (i.e. Cerner)			
<input type="checkbox"/> Confirmed through assessment and clinical evaluation					
<b>Chronic Health Condition</b>		<input type="checkbox"/> Yes (Answer Questions Below)	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
1. Expected to be of long-continued and indefinite duration and substantially impairs one's ability to live independently?					
<input type="checkbox"/> Yes		<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	
<b>Development Disability</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
<b>Drug Use Disorder</b>		<input type="checkbox"/> Yes (Answer Questions Below)	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
1. Expected to be of long-continued and indefinite duration and substantially impairs one's ability to live independently?					
<input type="checkbox"/> Yes		<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	
2. Documentation of disability and severity on file? (Staff Answer)					
		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
3. How confirmed? PATH ONLY (Staff Answer)					
<input type="checkbox"/> Unconfirmed; presumptive or self-report		<input type="checkbox"/> Confirmed by prior evaluation or clinical records (i.e. Cerner)			
<input type="checkbox"/> Confirmed through assessment and clinical evaluation					
<b>HIV/AIDS</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
<b>Mental Health Disorder</b>		<input type="checkbox"/> Yes (Answer Questions Below)	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
1. Expected to be of long-continued and indefinite duration and substantially impairs one's ability to live independently?					
<input type="checkbox"/> Yes		<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	
2. Documentation of disability and severity on file? (Staff Answer)					
		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
3. How confirmed? PATH ONLY (Staff Answer)					
<input type="checkbox"/> Unconfirmed; presumptive or self-report		<input type="checkbox"/> Confirmed by prior evaluation or clinical records (i.e. Cerner)			
<input type="checkbox"/> Confirmed through assessment and clinical evaluation					
4. Serious mental illness (SMI) and if SMI, how confirmed? PATH ONLY (Staff Answer)					
<input type="checkbox"/> No		<input type="checkbox"/> Unconfirmed; presumptive or self-report			
<input type="checkbox"/> Confirmed by prior evaluation or clinical records (ie Cerner)		<input type="checkbox"/> Confirmed through assessment and clinical evaluation			
<b>Physical Disability</b>		<input type="checkbox"/> Yes (Answer Questions Below)	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
1. Expected to be of long-continued and indefinite duration and substantially impairs one's ability to live independently?					
<input type="checkbox"/> Yes		<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	
<b>Disabling Condition – If Developmental, HIV or “Yes” to “Expected to be...” for any of the above barriers then this must be answered “Yes.”</b>					
<input type="checkbox"/> Yes		<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	
<b>Domestic Violence</b>					
<b>Domestic Violence Experience?</b>		<input type="checkbox"/> Yes (Answer questions below)	<input type="checkbox"/> Client Refused		<input type="checkbox"/> Client Doesn't Know
		<input type="checkbox"/> No			
<b>When Experience Occurred?</b>		<input type="checkbox"/> Within the past 3 months	<input type="checkbox"/> One year ago or more		
		<input type="checkbox"/> 3 months to 6 months ago	<input type="checkbox"/> Client Doesn't Know		
		<input type="checkbox"/> 6 months to one year	<input type="checkbox"/> Client Refused		
<b>If yes, are you currently fleeing?</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know		
		<input type="checkbox"/> No	<input type="checkbox"/> Client Refused		

**Financial Assessment**

Income Source <input type="checkbox"/> Yes (Check all Sources that Apply) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	Stated Income (Monthly)	Non-Cash Resources <input type="checkbox"/> Yes (Check all Sources that Apply) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	Stated Amounts (Monthly)
<input type="checkbox"/> Earned Income (employment wages / cash)	\$	<input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants and Children	\$
<input type="checkbox"/> Unemployment Insurance	\$	<input type="checkbox"/> Food Stamps (CalFresh) SNAP	\$
<input type="checkbox"/> Supplemental Security Income (SSI)	\$	<input type="checkbox"/> CalWorks Child Care/TANF Child Care Services	\$
<input type="checkbox"/> Social Security Disability Income (SSDI)	\$	<input type="checkbox"/> CalWorks Transportation (TANF)	\$
<input type="checkbox"/> Private Disability Insurance	\$	<input type="checkbox"/> Other CalWorks-Funded Services (TANF)	\$
<input type="checkbox"/> Workers Compensation	\$	<input type="checkbox"/> Other	\$
<input type="checkbox"/> VA Service-Connected Disability Compensation	\$		
<input type="checkbox"/> VA Non-Service-Connected Disability Pension	\$		
<input type="checkbox"/> Pension or Retirement income from a job	\$		
<input type="checkbox"/> TANF	\$		
<input type="checkbox"/> General Assistance	\$		
<input type="checkbox"/> Retirement (Social Security) (SSA)	\$		
<input type="checkbox"/> Child Support	\$		
<input type="checkbox"/> Alimony	\$		
<input type="checkbox"/> Other Income	\$		

**Date of Contact** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Current Living Situation: Outreach Contact**

**Record the client's current living situation information below.**

**1. Living Situation:**

- Place not meant for habitation
- Emergency shelter, including hotel or motel paid for with emergency shelter voucher or RHY funded Host Home shelter (i.e. CHSS, Mission, Respite, Rest House)
- Safe Haven
- Other (i.e. TH & PH)
- Worker unable to determine