

HMIS Intake and Enrollment Form SSVF RRH & HP

Client ID: _____

Project Name: _____

Staff Completing HMIS Form: _____

Identification - All fields required unless otherwise noted

First Name _____ Middle Name _____

Last Name _____ Suffix _____

Name Data Quality: Did the client provide their full name?	Social Security Number (SSN) _____-_____-_____	Birth Date (DOB) ____/____/_____
<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"/> Approximate or partial DOB reported <input type="checkbox"/> Full 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?)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
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Relationship to Head of Household	<input type="checkbox"/> Self <input type="checkbox"/> Son <input type="checkbox"/> Daughter	<input type="checkbox"/> Dependent Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other: Family Member	<input type="checkbox"/> Other: Non-Family Member
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Disabling Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
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Percent of AMI	<input type="checkbox"/> Less than 30% <input type="checkbox"/> 30% to 50% <input type="checkbox"/> Greater than 50%
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VAMC Station Number	<input type="checkbox"/> 640 Palo Alto <input type="checkbox"/> 662 San Francisco <input type="checkbox"/> Other: _____
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Project Start Date:	____/____/____
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Housing Move in Date (All PH – RRH ONLY)	____/____/____
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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)

Literally Homeless Situations

1. What was the living Situation you were living in immediately prior to project entry?

- Place not meant for habitation
- Emergency shelter, including hotel or motel paid for with emergency shelter voucher or RHY funded Host Home shelter
- Safe Haven

2. Length of stay in prior living situation?

- One night or less
- Two to six nights
- One week or more, but less than one month
- One month or more, but less than 90 days
- 90 days or more, but less than one year
- One year or longer
- Client doesn't know
- Client refused

**3. What approximate date did you start living on the streets, emergency shelter, or safe haven?
(Approximate date homelessness started)**

_____/_____/_____

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?

- One Time
- Two Times
- Three Times
- Four or more times
- Client Doesn't Know
- Client Refused

5. Total number of months homeless on the streets, in ES, or SH in the past three years?

- One Month (this time is the first month)
- 2-12 (months)
- More than 12
- Client Doesn't Know
- Client Refused

Institutional Situations

1. What was the living Situation you were living in immediately prior to project entry?

- Foster care home or foster care group home
- Hospital or other residential 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 or detox center

2. Did you stay less than 90 Days

- Yes (Continue to questions 3-4)
- No (Continue to question 3 and then Enter Wellness Assessment)

3. Length of stay in prior living Situation?

- One night or less
- Two to six nights
- One week or more, but less than one month
- One month or more, but less than 90 days
- 90 days or more, but less than one year
- One year or longer
- Client doesn't know
- Client refused

4. On the night before did you stay on the street, Emergency Shelter, or Safe Haven

- Yes(Continue to questions 5-7)
- Client Doesn't Know
- No (Continue with Wellness Assessment)
- Client Refused

**5. What approximate date did you start living on the streets, emergency shelter, or safe haven?
(Approximate date homelessness started)**

_____/_____/_____

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?

- One Time
- Two Times
- Three Times
- Four or more times
- Client Doesn't Know
- Client Refused

7. Total number of months homeless on the streets, in ES, or SH in the past three years?

- One Month (this time is the first month)
- 2-12 (months)
- More than 12
- Client Doesn't Know
- Client Refused

Transitional & Permanent Housing Situations

1. What was the living Situation you were living in immediately prior to project entry?

- Residential project or halfway house with no homeless criteria
- Hotel or motel paid for without emergency shelter voucher
- Rental by client, with VASH housing subsidy
- Transitional housing for homeless persons (including homeless youth)
- Host Home (non-crisis)
- Staying or living in a friend's room, apartment or house
- Staying or living in a family member's room, apartment or house
- Rental by client, with GPD TIP subsidy
- Permanent housing (Other than RRH) for formerly homeless persons
- Rental by client, with RRH or equivalent subsidy
- Rental by client, with HCV voucher (tenant or project based)
- Rental by client, in a public housing unit
- Rental by client, no ongoing housing subsidy
- Rental by client, with other ongoing housing subsidy
- Owned by client, with ongoing housing subsidy
- Owned by client, no ongoing housing subsidy
- Client Doesn't Know
- Client Refused

4. On the night before did you stay on the street, Emergency Shelter, or Safe Haven

- Yes(Continue to questions 5-7)
- Client Doesn't Know

- No (Continue with Wellness Assessment)
- Client Refused

**5. What approximate date did you start living on the streets, emergency shelter, or safe haven?
(Approximate date homelessness started)**

_____/_____/_____

6. How many times has the client been homeless on the streets, in shelters in the past 3 years?

- One Time
- Two Times
- Three Times
- One Month (this time is the first month)
- 2-12 (months)

- Four or more times
- Client Doesn't Know
- Client Refused
- More than 12
- Client Doesn't Know
- Client Refused

7. Total number of months homeless on the streets, in ES, or SH in the past three years

2. Did you stay less than 7 Nights

- Yes (Continue to questions 3-4)
- No (Answer 3 then continue to Wellness Assessment)

3. Length of stay in prior living Situation?

- One night or less
- Two to six nights
- One week or more, but less than one month
- One month or more, but less than 90 days
- 90 days or more, but less than one year
- One year or longer
- Client doesn't know
- Client refused

Last Permanent Address (Head of Household)			
Street Address		Address Data Quality	
City		<input type="checkbox"/> Full Address Reported <input type="checkbox"/> Incomplete or Estimated address reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
State			
Zip			
Health Insurance			
<input type="checkbox"/> Yes (Enter the Source)		<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know
		<input type="checkbox"/> Client Refused	
Health Insurance Sources	<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 _____	
Military Service History			
Date Entered Military Service	____/____/____	Date Separated Military Service	____/____/____
Branch of the Military	<input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Navy <input type="checkbox"/> Marines	<input type="checkbox"/> Coast Guard <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
Discharge Status	<input type="checkbox"/> Honorable <input type="checkbox"/> General under Honorable Conditions <input type="checkbox"/> Under other than honorable conditions (OTH) <input type="checkbox"/> Bad conduct	<input type="checkbox"/> Dishonorable <input type="checkbox"/> Uncharacterized <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
Theater of Operations	<input type="checkbox"/> Yes (Answer questions below)	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Please Mark All that apply	<input type="checkbox"/> World War II <input type="checkbox"/> Vietnam War <input type="checkbox"/> Persian Gulf War (Operation Desert Storm) <input type="checkbox"/> Afghanistan (Operation Enduring Freedom) <input type="checkbox"/> Iraq (Operation Iraqi Freedom)	<input type="checkbox"/> Iraq (Operation New Dawn) <input type="checkbox"/> Other Peace-keeping Operations or Military Interventions (Such as Lebanon, Panama, Somalia, Bosnia, Kosovo) <input type="checkbox"/> Korean War	
Connection with SOAR	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Domestic Violence			
Domestic Violence Experience?	<input type="checkbox"/> Yes (Answer questions below) <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
When Experience Occurred?	<input type="checkbox"/> Within the past 3 months <input type="checkbox"/> 3 months to 6 months ago <input type="checkbox"/> 6 months to one year	<input type="checkbox"/> One year ago or more <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
If yes, are you currently fleeing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	

Financial Assessment			
Income Source	Stated Income (Monthly)	Non-Cash Resources	Stated Amounts (Monthly)
<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		<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	
<input type="checkbox"/> Earned Income (<i>employment wages / cash</i>)	\$	<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)	\$		
<input type="checkbox"/> Child Support	\$		
<input type="checkbox"/> Alimony	\$		
<input type="checkbox"/> Other Income	\$		
Employment Assessment			
Is the client employed? <input type="checkbox"/> Yes (Answer Below) <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Seasonal/Sporadic	<input type="checkbox"/> No (Answer Below) <input type="checkbox"/> Looking for Work <input type="checkbox"/> Unable to Work <input type="checkbox"/> Not looking for work	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
Educational Assessment			
Highest Grade Completed <input type="checkbox"/> No School Completed <input type="checkbox"/> School program does not have a grade level <input type="checkbox"/> Nursery School to 4 th <input type="checkbox"/> 5 th or 6 th grade <input type="checkbox"/> 7 th or 8 th grade <input type="checkbox"/> 9 th grade	<input type="checkbox"/> 10 th grade <input type="checkbox"/> 11 th grade <input type="checkbox"/> 12 th grade, No Diploma <input type="checkbox"/> High School Diploma <input type="checkbox"/> GED <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Associates Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree <input type="checkbox"/> Doctorate Degree <input type="checkbox"/> Other Graduate/Professional degree <input type="checkbox"/> Vocational certification/ Certificate of advanced training or skilled artisan	

HP Targeting Criteria – For (HP) Homeless Prevention Only	
Is Homelessness Prevention targeting screeners required?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Housing loss expected within ...	<input type="checkbox"/> 1-6 days <input type="checkbox"/> 7-13 days <input type="checkbox"/> 14-21 days <input type="checkbox"/> More than 21 days
Current household income	<input type="checkbox"/> \$0 (i.e., not employed, not receiving cash benefits, no other current income) <input type="checkbox"/> 1-14% of Area Median Income (AMI) for household size <input type="checkbox"/> 15-30% of AMI for household size <input type="checkbox"/> More than 30% of AMI for household size
History of literal homelessness (Street/Shelter/Transitional Housing) (any adult)	<input type="checkbox"/> Most recent episode occurred within the last year <input type="checkbox"/> Most recent episode occurred more than one year ago <input type="checkbox"/> None
Head of Household is not a current leaseholder	<input type="checkbox"/> No <input type="checkbox"/> Yes
Head of Household (HoH) never been a leaseholder	<input type="checkbox"/> No <input type="checkbox"/> Yes
Currently at risk of losing a tenant-based housing subsidy or housing in a subsidized building or unit (household)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Rental evictions with in the past 7 years (any adult)	<input type="checkbox"/> No prior rental evictions <input type="checkbox"/> 1 prior rental eviction <input type="checkbox"/> 2 or more prior rental evictions <input type="checkbox"/>
Criminal record for arson, drug dealing or manufacture, or felony offense against persons or property (any adult)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Incarcerated as adult (any adult in household)	<input type="checkbox"/> Not incarcerated <input type="checkbox"/> Incarcerated once <input type="checkbox"/> Incarcerated two or more times
Discharged from jail or prison within last six months after incarceration of 90 days or more (adults)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Registered sex offender (any household members)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Head of household with disabling condition (physical health, mental health, substance use) that directly affects ability to secure/maintain housing?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Currently pregnant (any household member)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Single parent household with minor child(ren)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Household includes one or more young children (age six or under), or a child who requires significant care?	<input type="checkbox"/> No <input type="checkbox"/> Youngest child is under 1 year old <input type="checkbox"/> Youngest child is 1 to 6 years old and/or one or more children (any age) require significant care
Household size of 5 or more requiring at least 3 bedrooms (due to age/gender mix)?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Household includes one or more members of an overrepresented population in the homelessness system when compared to the general population?	<input type="checkbox"/> No <input type="checkbox"/> Yes
HP applicant total points	
Grantee targeting threshold score	

SSVF Services			
SSVF Services Provided		Date of Service	
<input type="checkbox"/> Outreach <input type="checkbox"/> Case Management <input type="checkbox"/> Returning Home A <input type="checkbox"/> Returning Home D <input type="checkbox"/> Rapid Resolution (RR) <input type="checkbox"/> Extended Shallow Subsidy			
Assistance obtaining VA benefits <input type="checkbox"/> VA vocational and rehabilitation counseling <input type="checkbox"/> Employment training services <input type="checkbox"/> Educational Assistance <input type="checkbox"/> Health care services			
Assistance obtaining/coordinating other public benefits, specify <input type="checkbox"/> Health care services <input type="checkbox"/> Daily living services <input type="checkbox"/> Personal financial planning services <input type="checkbox"/> Transportation service <input type="checkbox"/> Income support services <input type="checkbox"/> Fiduciary and representation payee services <input type="checkbox"/> Legal services-child support <input type="checkbox"/> Legal services-eviction prevention <input type="checkbox"/> Legal services-outstanding fines and penalties <input type="checkbox"/> Legal services-restore/acquire driver license <input type="checkbox"/> Legal services-other <input type="checkbox"/> Child care <input type="checkbox"/> Housing counseling			
Direct provision of other public benefits, specify <input type="checkbox"/> Personal financial planning services <input type="checkbox"/> Transportation service <input type="checkbox"/> Income support services <input type="checkbox"/> Fiduciary and representation payee services <input type="checkbox"/> Legal services-child support <input type="checkbox"/> Legal services-eviction prevention <input type="checkbox"/> Legal services-outstanding fines and penalties <input type="checkbox"/> Legal services-restore/acquire driver license <input type="checkbox"/> Legal services-other <input type="checkbox"/> Child care <input type="checkbox"/> Housing counseling			
Other (non-TFA) supportive services approved by VA, Specify below <input type="checkbox"/> Referral to VA Healthcare <input type="checkbox"/> Other non-TFA			
Financial Assistance Provided: VA SSVF			
Date Financial Assistance Provided: _____ / _____ / _____			
	Amount		Amount
<input type="checkbox"/> Rental Assistance	\$	<input type="checkbox"/> Child care	\$
<input type="checkbox"/> Utility Fee Payment Assistance	\$	<input type="checkbox"/> General housing stability assistance	\$
<input type="checkbox"/> Utility Deposit	\$	<input type="checkbox"/> Emergency housing assistance	\$
<input type="checkbox"/> Security Deposit	\$	<input type="checkbox"/> Extended Shallow Subsidy Rental Assistance	\$
<input type="checkbox"/> Moving Costs	\$	<input type="checkbox"/> Food Assistance	\$
<input type="checkbox"/> Transportation Services: token/vouchers	\$		
<input type="checkbox"/> Transportation Services: Vehicle repair/maintenance	\$		