



HMIS # _____
CM Name _____
Project Start Date ____ / ____ / ____

Monterey/San Benito County HMIS Standard Intake - ADULT

This form is designed to be completed by a service provider while interviewing a client.
A separate Standard Intake form should be completed for each member of the household.

Household Information Is client: Single Adult Adult in Household

If checked Single Adult	Go to Client Profile	
If checked Adult in Household	Are you the Head of Household (HoH)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you are in a household, what is your relationship to the HoH?	<input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Roommate <input type="checkbox"/> Grandchild	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Niece <input type="checkbox"/> Nephew <input type="checkbox"/> Grandparent <input type="checkbox"/> Significant Other <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Stepson

Client Profile

Social Security Number		
First Name	Middle	
Last Name		
Alias (If multiple aliases, separate by commas)		
Quality of Name	<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
U.S. Military Veteran (If Yes, complete Veteran Information below)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Disabling Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Primary Phone Number		

Client Demographics

Date of Birth	_____ / _____ / _____	
Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Trans Female (MTF or Male to Female) <input type="checkbox"/> Trans Male (FTM or Female to Male)	<input type="checkbox"/> Gender Non-Conforming (i.e. not exclusively male or female) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Ethnicity	Race	
<input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Date of Engagement (Street Outreach or Night-by-Night Emergency Shelter)

Record the date the client became 'engaged' in project services after one or more contacts with outreach or night-by-night shelter.

Date of Engagement	_____ / _____ / _____
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Complete Housing Move-In Date When Client Moves Into a Permanent Housing Unit

Reported The Housing Move-in Date is the date the client moves into a permanent housing unit while he or she is enrolled in a PH project.

Housing Move-In Date	_____ / _____ / _____
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Prior Living Situation

Prior Street Address		
Prior City		
Prior State	Prior Zip Code	
Prior Address Data Quality	<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

**Answer 3. 917A Living Situation questions if entering Street Outreach, Emergency Shelter, & Safe Haven.
Answer 3.917 B questions if entering any other program.**

3. 917A Prior Living Situation

<p>Type of Residence</p>	<p><u>Homeless Situation</u></p> <p><input type="checkbox"/> Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport/or anywhere outside)</p> <p><input type="checkbox"/> Emergency Shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter</p> <p><input type="checkbox"/> Safe Haven</p> <p><u>Institutional Situations</u></p> <p><input type="checkbox"/> Foster care home or foster care group home</p> <p><input type="checkbox"/> Hospital or other residential non—psychiatric medical facility</p> <p><input type="checkbox"/> Jail, prison or juvenile detention facility</p> <p><input type="checkbox"/> Long-term care facility or nursing home</p> <p><input type="checkbox"/> Psychiatric hospital or other psychiatric facility</p> <p><input type="checkbox"/> Substance abuse treatment facility or detox center</p> <p><u>Transitional & Permanent Housing Situation</u></p> <p><input type="checkbox"/> Residential project or halfway house with no homeless criteria</p> <p><input type="checkbox"/> Hotel or motel Paid for without emergency shelter voucher</p> <p><input type="checkbox"/> Transitional housing for homeless persons (including homeless youth)</p> <p><input type="checkbox"/> Host Home (non-crisis)</p> <p><input type="checkbox"/> Rental by client with GPD TIP housing subsidy</p> <p><input type="checkbox"/> Rental by client, with VASH housing subsidy</p> <p><input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons</p> <p><input type="checkbox"/> Rental by client, with RRH or equivalent subsidy</p> <p><input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based)</p> <p><input type="checkbox"/> Rental by client in a public housing unit</p> <p><input type="checkbox"/> Rental by client, no ongoing housing subsidy</p> <p><input type="checkbox"/> Rental by client, with other ongoing housing subsidy</p> <p><input type="checkbox"/> Owned by client, with ongoing housing subsidy</p> <p><input type="checkbox"/> Owned by client, no ongoing housing subsidy</p> <p><u>Other</u></p> <p><input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused</p>
<p>Length of stay in previous place</p>	<p><input type="checkbox"/> One night or less</p> <p><input type="checkbox"/> Two to six nights</p> <p><input type="checkbox"/> One week or more, but less than one month</p> <p><input type="checkbox"/> One month or more, but less than 90 days</p> <p><input type="checkbox"/> 90 days or more, but less than one year</p> <p><input type="checkbox"/> One year or longer</p> <p><input type="checkbox"/> Client doesn't know</p> <p><input type="checkbox"/> Client refused</p>
<p>Approximate date homelessness started: _____/_____/_____</p> <p>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</p> <p>Total number of months homeless on the street, in ES, or SH in the past three years</p>	<p><input type="checkbox"/> One Time</p> <p><input type="checkbox"/> Two Times</p> <p><input type="checkbox"/> Three Times</p> <p><input type="checkbox"/> Four or more times</p> <p><input type="checkbox"/> Client doesn't know</p> <p><input type="checkbox"/> Client refused</p> <p><input type="checkbox"/> One month (this time is the first month)</p> <p><input type="checkbox"/> 2 <input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4 <input type="checkbox"/> 5</p> <p><input type="checkbox"/> 6 <input type="checkbox"/> 7</p> <p><input type="checkbox"/> 8 <input type="checkbox"/> 9</p> <p><input type="checkbox"/> 10 <input type="checkbox"/> 11</p> <p><input type="checkbox"/> 12 <input type="checkbox"/> More than 12 months</p> <p><input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused</p>

3. 917B Prior Living Situation

Type of Residence	<p><u>Homeless Situation</u> If client is in homeless situation, complete 3.917A Living Situation (previous page)</p> <p><u>Institutional Situation</u></p> <ul style="list-style-type: none"> <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 <p><u>Transitional & Permanent Housing Situation</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Hotel or motel Paid for without emergency shelter voucher <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Rental by client with GPD TIP housing subsidy <input type="checkbox"/> Rental by client, with VASH housing 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 <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 <p><u>Other</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
Length of Stay in Prior Living Situation:	<ul style="list-style-type: none"> <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
If Institutional Situation, did you stay less than 90 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If answer is Yes, then answer:	On the night before - stayed on the streets, ES or Safe Haven
If Transitional/Permanent, did you stay less than 7 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If answer is Yes, then answer:	On the night before - stayed on the streets, ES or Safe Haven
On the night before did stay on the streets, ES or SH?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, then answer next 3 questions	
Approximate date homelessness started: _____/_____/_____	
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	<ul style="list-style-type: none"> <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
Total number of months homeless on the street, in ES, or SH in the past three years	<ul style="list-style-type: none"> <input type="checkbox"/> One month (this time is the first month) <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> More than 12 months <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused

Disabling Conditions and Barriers

<p>Does the client have a disabling condition?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
<p>If Yes, please complete the following for each disability type</p>		
<p>Alcohol Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>	<p>Condition Long Term?</p> <p>If Yes, If the problem is expected to be of long-continued and indefinite duration and substantially impedes a client's ability to live independently.</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
<p>Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>	<p>Condition Long Term?</p> <p>If Yes, If the problem is expected to be of long-continued and indefinite duration and substantially impedes a client's ability to live independently.</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
<p>Both Alcohol & Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>	<p>Condition Long Term?</p> <p>If Yes, If the problem is expected to be of long-continued and indefinite duration and substantially impedes a client's ability to live independently.</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
<p>Chronic Health Condition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>	<p>Condition Long Term?</p> <p>If Yes, If the problem is expected to be of long-continued and indefinite duration and substantially impedes a client's ability to live independently.</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
<p>Developmental Disability</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	

Disabling Conditions and Barriers/ Domestic Violence

<p>Physical Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>	<p>Condition Long Term? If Yes, If the problem is expected to be of long-continued and indefinite duration and substantially impedes a client's ability to live independently.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>
<p>HIV - AIDS</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>
<p>Mental Health Problem <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>	<p>Condition Long Term? If Yes, If the problem is expected to be of long-continued and indefinite duration and substantially impedes a client's ability to live independently.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>
<p>Domestic Violence Victim/Survivor <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>	<p>Last Occurrence How long ago did the person have the most recent experience?</p> <p><input type="checkbox"/> Within the past three months <input type="checkbox"/> Three to six months ago (excluding six months exactly) <input type="checkbox"/> Six months to one year ago (excluding one year exactly) <input type="checkbox"/> One year ago or more <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>
<p>Are You Currently Fleeing?</p>	<p>Are you currently fleeing domestic violence?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>

Monthly Income – Cash Benefits

<p style="text-align: center;">Income from any source?</p> <p><input type="checkbox"/> Earned Income \$ _____</p> <p><input type="checkbox"/> Unemployment Insurance \$ _____</p> <p><input type="checkbox"/> Worker's Compensation \$ _____</p> <p><input type="checkbox"/> Private Disability Insurance \$ _____</p> <p><input type="checkbox"/> VA Service-Connected Disability Pension \$ _____</p> <p><input type="checkbox"/> Social Security Disability Insurance SSDI \$ _____</p> <p style="text-align: right;">Total Cash Income for Individual</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused</p> <p><input type="checkbox"/> Supplemental Security Income SSI \$ _____</p> <p><input type="checkbox"/> Retirement income from Social Security \$ _____</p> <p><input type="checkbox"/> VA Non-service connect disability pension \$ _____</p> <p><input type="checkbox"/> Pension or Retirement Income from a Former Job \$ _____</p> <p><input type="checkbox"/> Temporary Assistance for Needy Families TANF \$ _____</p> <p><input type="checkbox"/> General Assistance (GA) \$ _____</p> <p><input type="checkbox"/> Alimony and Other Spousal Support \$ _____</p> <p><input type="checkbox"/> Child Support \$ _____</p> <p><input type="checkbox"/> Other Cash Income \$ _____</p> <p>If Other Specify: _____</p> <p>TOTAL: \$ _____</p>
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Non-Cash Benefits

<p style="text-align: center;">Receiving Non-Cash Benefits?</p> <p><input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP)</p> <p><input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)</p> <p><input type="checkbox"/> TANF Childcare Services</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused</p> <p><input type="checkbox"/> TANF Transportation Services</p> <p><input type="checkbox"/> Other TANF-Funded Services</p> <p><input type="checkbox"/> Other Non-Cash Benefit</p> <p>If Other Specify: _____</p>
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Health Insurance

<p style="text-align: center;">Covered by health insurance?</p> <p><input type="checkbox"/> Medicaid</p> <p><input type="checkbox"/> Medicare</p> <p><input type="checkbox"/> State Children's Health Insurance Program</p> <p><input type="checkbox"/> Veteran's Administration (VA) Medical Services</p> <p><input type="checkbox"/> Employer-Provided Health Insurance</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused</p> <p><input type="checkbox"/> Health Insurance Obtained Through COBRA</p> <p style="padding-left: 100px;"><input type="checkbox"/> Private Pay Health Insurance</p> <p><input type="checkbox"/> State Health Insurance for Adults</p> <p><input type="checkbox"/> Indian Health Services Program</p> <p><input type="checkbox"/> Other Health Insurance</p> <p>If Other Specify: _____</p>
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Employment Status

Employed	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know
	<input type="checkbox"/> No	<input type="checkbox"/> Client Refused
If Yes, Type of Employment	<input type="checkbox"/> Full-time	
	<input type="checkbox"/> Part-time	
	<input type="checkbox"/> Seasonal/Sporadic (including day labor)	
If No, Why Not Employed	<input type="checkbox"/> Looking for work	
	<input type="checkbox"/> Unable to work	
	<input type="checkbox"/> Not looking for work	

Last Grade Completed

Last Grade Completed	<input type="checkbox"/> Less than Grade 5	<input type="checkbox"/> GED
	<input type="checkbox"/> Grades 5-6	<input type="checkbox"/> Some college
	<input type="checkbox"/> Grades 7-8	<input type="checkbox"/> Associate's degree
	<input type="checkbox"/> Grades 9-11	<input type="checkbox"/> Bachelor's degree
	<input type="checkbox"/> Grade 12/ High school diploma	<input type="checkbox"/> Graduate degree
	<input type="checkbox"/> School program does not have grade levels	<input type="checkbox"/> Vocational certification
		<input type="checkbox"/> Client Doesn't Know
		<input type="checkbox"/> Client Refused

I, (Adult client or Head of Household) certify that the information I have provided here is true/correct to the best of my knowledge.

Print Name of Client

Signature of Client

Date

Print Name of Intake Worker

Signature of Intake Worker

Date