



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 Address Data Quality	Prior Zip Code	
<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

Type of Residence	<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>
Length of stay in previous place	<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>
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><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>
Total number of months homeless on the street, in ES, or SH in the past three years	<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> <p><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> <p><u>Transitional & Permanent Housing Situation</u></p> <p><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> <p><u>Other</u> <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused</p>
Length of Stay in Prior Living Situation:	<p><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</p> <p><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</p>
If Institutional Situation, did you stay less than 90 days? If answer is Yes, then answer:	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>On the night before - stayed on the streets, ES or Safe Haven</p>
If Transitional/Permanent, did you stay less than 7 days? If answer is Yes, then answer:	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>On the night before - stayed on the streets, ES or Safe Haven</p>
On the night before did stay on the streets, ES or SH? If Yes, then answer next 3 questions	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</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><input type="checkbox"/> One Time <input type="checkbox"/> Two Times <input type="checkbox"/> Three Times</p> <p><input type="checkbox"/> Four or more times <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused</p>
Total number of months homeless on the street, in ES, or SH in the past three years	<p><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</p> <p><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</p>

Disabling Conditions and Barriers

Does the client have a disabling condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
If Yes, please complete the following for each disability type		
Alcohol Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
Both Alcohol & Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
Chronic Health Condition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
Developmental Disability	<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

Physical Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
HIV - AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Mental Health Problem <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Domestic Violence Victim/Survivor <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	Last Occurrence How long ago did the person have the most recent experience? <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
Are You Currently Fleeing?	Are you currently fleeing domestic violence? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Monthly Income – Cash Benefits

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

Non-Cash Benefits

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

Health Insurance

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

Employment Status

Employed	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <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"/> Grades 5-6 <input type="checkbox"/> Grades 7-8 <input type="checkbox"/> Grades 9-11 <input type="checkbox"/> Grade 12/ High school diploma <input type="checkbox"/> School program does not have grade levels	<input type="checkbox"/> GED <input type="checkbox"/> Some college <input type="checkbox"/> Associate's degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Graduate degree <input type="checkbox"/> Vocational certification <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
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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