THE COALITION
OF HOMELESS SERVICES PROVIDERS

HMIS #
CM Name:
Project Entry Date:

HMIS Standard Intake Form

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

Client Profile

First Name	**Middle**
Last Name	
Date of Birth	
Social Security Number	
U.S. Military Veteran	❑ Yes ❑ Client Doesn't Know ❑ No ❑ Client Refused
Gender	❑ Female ❑ Transgender ❑ Male ❑ Client Doesn't Know ❑ A gender other than singularly female or male (e.g., non-binary, genderfluid, agender, culturally specific gender) ❑ Client Refused
Race	❑ American Indian, Alaska Native, or Indigenous ❑ Asian or Asian American ❑ Black, African American, or African ❑ Native Hawaiian or Pacific Islander ❑ White ❑ Client Doesn't Know ❑ Client Refused
Ethnicity	❑ Non-Hispanic/Non-Latin(a)(o)(x) ❑ Hispanic/Latin(a)(o)(x) ❑ Client Doesn't Know ❑ Client Refused
If the client is a member of a household, please complete the household information section	

Household Information

Household Type	❑ Female Single Parent ❑ Male Single Parent ❑ Two Parent Family ❑ Couple with No Children ❑ Foster Parent(s) ❑ Grandparent(s) and Child	❑ Multi-Generational ❑ Non-Custodial Caregivers(s) ❑ Other ❑ Refused ❑ Unknown	
Head of Household	❑ Yes ❑ No		
Relationship to Head of Household	❑ Self ❑ Wife ❑ Husband ❑ Significant Other ❑ Son ❑ Daughter ❑ Step-Son	❑ Step-Daughter ❑ Grandson ❑ Granddaughter ❑ Father ❑ Mother ❑ Grandfather	❑ Grandmother ❑ Other Relative ❑ Other Non-Relative ❑ Client Doesn't Know ❑ Refused ❑ Unknown

Contact Information and Address Prior to Project Entry (If applicable)

Phone **Email**		
Street Address **City** **State**	**Zip**	
Address Data Quality	❑ Full Address Reported ❑ Incomplete or estimated address reported	
Start Date	_____/_____/_____	
If no longer living here, when did you leave?	_____/_____/_____	
Reason for leaving residence	❑ Building Condemned ❑ Evicted ❑ Family/Friend Conflict ❑ Fire	❑ Moved to New Residence ❑ Overcrowding ❑ Unable to pay rent ❑ Other
Landlord information	Name:	
	Address:	
	Phone Number:	

Prior Living Situation (Where the client stayed last night)

Type of Residence:

Homeless Situation

- ❑ Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport/or anywhere outside)
- ❑ Emergency Shelter, including hotel or motel paid for with emergency shelter voucher or RHY-funded Host Home shelter
- ❑ Safe Haven

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

- ❑ One Time
- ❑ Two Times
- ❑ Three Times
- ❑ Four or more times
- ❑ Client doesn't know
- ❑ Client refused

Total number of months homeless on the street, in ES, or SH in the past three years

- ❑ One month (this time is the first month)
- ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6
- ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11
- ❑ 12 ❑ More than 12 months
- ❑ Client doesn't know ❑ Client refused

Institutional Situation

- ❑ 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

Temporary & Permanent Housing Situation

- ❑ Residential project or halfway house with no homeless criteria
- ❑ Hotel or motel paid for without emergency shelter voucher
- ❑ Transitional housing with 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 housing subsidy
- ❑ Rental by client, with VASH housing 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

Other

- ❑ Client doesn't know
- ❑ Client refused

On the night before did you stay on the streets, Emergency Shelter, or Safe Haven?

- ❑ Yes
- ❑ No

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

Monthly Income – Cash Benefits (For clients aged 18+ only)

Income from any source?	❑ Yes ☐ No ☐ Client doesn't know ☐ Client refused
❑ Alimony or Other Spousal Income $_____ **Date start receiving:** _____ ❑ Child Support $_____ **Date start receiving:** _____ ❑ Earned Income $_____ **Date start receiving:** _____ ❑ General Assistance $_____ **Date start receiving:** _____ ❑ Other $_____ **Date start receiving:** _____ If Other specify: ❑ Pension or retirement from another job $ _____ **Date start receiving:** _____ ❑ Private disability insurance $_____ **Date start receiving:** _____	❑ Retirement income from Social Security $_____ **Date start receiving:** _____ ❑ SSDI $_____ **Date start receiving:** _____ ❑ SSI $_____ **Date start receiving:** _____ ❑ TANF $_____ **Date start receiving:** _____ ❑ Unemployment Insurance $_____ **Date start receiving:** _____ ❑ VA Non-service connect disability pension $_____ **Date start receiving:** _____ ❑ VA Service connected disability compensation $_____ **Date start receiving:** _____ ❑ Worker's compensation $_____ **Date start receiving:** _____

Non-Cash Benefits (For clients aged 18+ only)

Non-cash benefit from any source?	❑ Yes ❑ No ❑ Client doesn't know ❑ Client refused
❑ Special supplement nutrition program for WIC $_____ **Date start receiving:** _____ ❑ Supplemental nutrition assistance program (Food Stamps) $_____ **Date start receiving:** _____ ❑ TANF-Child care services $_____ **Date start receiving:** _____	❑ TANF Transportation services $_____ **Date start receiving:** _____ ❑ Other TANF funded services $_____ **Date start receiving:** _____ ❑ Other Source $_____ **Date start receiving:** _____ If Other, specify:

Health Insurance

Covered by health insurance?	❑ Yes ❑ No ❑ Client doesn't know ❑ Client refused
❑ Medicaid (Medi-Cal) **Date start receiving:** _____ ❑ Medicare **Date start receiving:** _____ ❑ State children's health insurance program **Date start receiving:** _____ ❑ Veteran's Administration (VA) Medical Services **Date start receiving:** _____ ❑ Employer-provided health insurance **Date start receiving:** _____ ❑ Health insurance obtained through COBRA **Date start receiving:** _____	❑ Private pay health insurance **Date start receiving:** _____ ❑ State health insurance for adults **Date start receiving:** _____ ❑ Indian health services program **Date start receiving:** _____ ❑ Other Source **Date start receiving:** _____ If Other, specify:

Disability

Does the client have a disabling condition?	❑ Yes ❑ No ❑ Client doesn't know ❑ Client refused
If Yes, please complete the following page for each disability type	

Disability Type

Alcohol Use Disorder	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	**Disability Start Date**	_____
Disability determination:	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	If Yes (to disability determination), Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Both Alcohol and Drug Use Disorder	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	**Disability Start Date**	_____
Disability determination:	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	If Yes (to disability determination), Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Chronic Health Condition	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	**Disability Start Date**	_____
Disability determination:	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	If Yes (to disability determination), Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Developmental	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	**Disability Start Date**	_____
Disability determination:	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	If Yes (to disability determination), Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Drug Use Disorder	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	**Disability Start Date**	_____
Disability determination:	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	If Yes (to disability determination), Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
HIV/AIDS	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	**Disability Start Date**	_____
Disability determination:	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	If Yes (to disability determination), Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Mental Health Disorder	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	**Disability Start Date**	_____
Disability determination:	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	If Yes (to disability determination), Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Physical	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	**Disability Start Date**	_____
Disability determination:	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	If Yes (to disability determination), Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused

Domestic Violence (For clients aged 18+ only)

Domestic Violence Victim/Survivor	❑ Yes ❑ Client Doesn't Know ❑ No ❑ Client Refused
If yes, when did experience occur?	❑ Within past three months ❑ Three months to less than six months ago (excluding six months exactly) ❑ Six months to less than one year ago (excluding one year exactly) ❑ One year or more ago ❑ Client doesn't know ❑ Client refused
If yes, are you currently fleeing?	❑ Yes ❑ Client Doesn't Know ❑ No ❑ Client Refused

Employment Status (For clients aged 18+ only)

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

Last Grade Completed

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