



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	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused
Sex	<input type="checkbox"/> Female <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Male <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected
Race and Ethnicity	<input type="checkbox"/> American Indian, Alaska Native, or Indigenous <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black, African American, or African <input type="checkbox"/> Hispanic/Latina/o <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Prefers Not to Answer
If the client is a member of a household, please complete the household information section	

Household Information

Household Type	<input type="checkbox"/> Female Single Parent <input type="checkbox"/> Grandparent(s) and Child <input type="checkbox"/> Male Single Parent <input type="checkbox"/> Multi-generational <input type="checkbox"/> Two Parent Family <input type="checkbox"/> Non-Custodial Caregivers(s) <input type="checkbox"/> Couple with No Children <input type="checkbox"/> Other <input type="checkbox"/> Foster Parent(s) <input type="checkbox"/> Refused <input type="checkbox"/> Unknown
Head of Household	<input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship to Head of Household	<input type="checkbox"/> Self <input type="checkbox"/> Step-son <input type="checkbox"/> Grandfather <input type="checkbox"/> Wife <input type="checkbox"/> Step-daughter <input type="checkbox"/> Grandmother <input type="checkbox"/> Husband <input type="checkbox"/> Grandson <input type="checkbox"/> Other Relative <input type="checkbox"/> Significant Other <input type="checkbox"/> Granddaughter <input type="checkbox"/> Other Non-Relative <input type="checkbox"/> Son <input type="checkbox"/> Father <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Daughter <input type="checkbox"/> Mother <input type="checkbox"/> Refused <input type="checkbox"/> Unknown

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

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

Prior Living Situation (Where the client stayed last night)

<p>Type of Residence:</p>	<p><u>Homeless Situation</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport/or anywhere outside) <input type="checkbox"/> Emergency Shelter, including hotel or motel paid for with emergency shelter voucher or RHY-funded Host Home shelter <input type="checkbox"/> Safe Haven <hr/> <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> <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 <p>Total number of months homeless on the street, in ES, or SH in the past three years</p> <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 <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>Temporary & 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 with 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 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 <hr/> <p>On the night before did you stay on the streets, Emergency Shelter, or Safe Haven?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Length of Stay in Prior Living Situation:</p>	<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

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

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"/> Alimony or Other Spousal Income \$ _____ Date start receiving: _____ <input type="checkbox"/> Child Support \$ _____ Date start receiving: _____ <input type="checkbox"/> Earned Income \$ _____ Date start receiving: _____ <input type="checkbox"/> General Assistance \$ _____ Date start receiving: _____ <input type="checkbox"/> Other \$ _____ Date start receiving: _____ If Other specify: _____ <input type="checkbox"/> Pension or retirement from another job \$ _____ Date start receiving: _____ <input type="checkbox"/> Private disability insurance \$ _____ Date start receiving: _____	<input type="checkbox"/> Retirement income from Social Security \$ _____ Date start receiving: _____ <input type="checkbox"/> SSDI \$ _____ Date start receiving: _____ <input type="checkbox"/> SSI \$ _____ Date start receiving: _____ <input type="checkbox"/> TANF \$ _____ Date start receiving: _____ <input type="checkbox"/> Unemployment Insurance \$ _____ Date start receiving: _____ <input type="checkbox"/> VA Non-service connect disability pension \$ _____ Date start receiving: _____ <input type="checkbox"/> VA Service connected disability compensation \$ _____ Date start receiving: _____ <input type="checkbox"/> Worker's compensation \$ _____ Date start receiving: _____

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

Non-cash benefit 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"/> Special supplement nutrition program for WIC \$ _____ Date start receiving: _____ <input type="checkbox"/> Supplemental nutrition assistance program (Food Stamps) \$ _____ Date start receiving: _____ <input type="checkbox"/> TANF-Child care services \$ _____ Date start receiving: _____	<input type="checkbox"/> TANF Transportation services \$ _____ Date start receiving: _____ <input type="checkbox"/> Other TANF funded services \$ _____ Date start receiving: _____ <input type="checkbox"/> Other Source \$ _____ Date start receiving: _____ 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 (Medi-Cal) Date start receiving: _____ <input type="checkbox"/> Medicare Date start receiving: _____ <input type="checkbox"/> State children's health insurance program Date start receiving: _____ <input type="checkbox"/> Veteran's Administration (VA) Medical Services Date start receiving: _____ <input type="checkbox"/> Employer-provided health insurance Date start receiving: _____ <input type="checkbox"/> Health insurance obtained through COBRA Date start receiving: _____	<input type="checkbox"/> Private pay health insurance Date start receiving: _____ <input type="checkbox"/> State health insurance for adults Date start receiving: _____ <input type="checkbox"/> Indian health services program Date start receiving: _____ <input type="checkbox"/> Other Source Date start receiving: _____ If Other, specify: _____

Disability

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 page for each disability type	

Disability Type

<p>Alcohol Use Disorder</p> <p>Disability determination:</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"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>	<p>Disability Start Date _____</p> <p>If Yes (to disability determination), Expected to be of long-continued and indefinite duration and substantially impairs 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>Both Alcohol and Drug Use Disorder</p> <p>Disability determination:</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"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>	<p>Disability Start Date _____</p> <p>If Yes (to disability determination), Expected to be of long-continued and indefinite duration and substantially impairs 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>Chronic Health Condition</p> <p>Disability determination:</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"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>	<p>Disability Start Date _____</p> <p>If Yes (to disability determination), Expected to be of long-continued and indefinite duration and substantially impairs 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>Developmental</p> <p>Disability determination:</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"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>	<p>Disability Start Date _____</p> <p>If Yes (to disability determination), Expected to be of long-continued and indefinite duration and substantially impairs 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>Drug Use Disorder</p> <p>Disability determination:</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"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>	<p>Disability Start Date _____</p> <p>If Yes (to disability determination), Expected to be of long-continued and indefinite duration and substantially impairs 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>Disability determination:</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"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>	<p>Disability Start Date _____</p> <p>If Yes (to disability determination), Expected to be of long-continued and indefinite duration and substantially impairs 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>Mental Health Disorder</p> <p>Disability determination:</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"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>	<p>Disability Start Date _____</p> <p>If Yes (to disability determination), Expected to be of long-continued and indefinite duration and substantially impairs 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>Physical</p> <p>Disability determination:</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"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>	<p>Disability Start Date _____</p> <p>If Yes (to disability determination), Expected to be of long-continued and indefinite duration and substantially impairs 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>

