

# FL511 - HMIS Intake - HUD CoC and ESG (HP/ES/TH Projects Only)

Project Start Date (Use for Back Date Mode in ODHMIS): \_\_\_\_/\_\_\_\_/\_\_\_\_ Staff Completing Intake: \_\_\_\_\_

Head of Household Name: \_\_\_\_\_ Client Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

**Household Type:**  Couple w/ No Children  Male Single Parent  Grandparent(s) and Child  Non-Custodial Caregiver(s)  
 Female Single Parent  Two Parent Family  Foster Parent(s)  Other: \_\_\_\_\_

For any answers below in which a client doesn't know or refuses to disclose information, please indicate **DK** (Doesn't Know) or **CR** (Client Refused).

Answer this section for each person in the household (complete additional data elements on the **Household Members** form and **Additional Adults** form).  
 Please use additional forms for households with more than 6 people.

Client Name	SS#	Veteran?	Date of Birth	Race (see below)	Ethnicity (see below)	Gender (see below)	Relationship to Head of Household
		<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___				<i>Self (HoH)</i>
		<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___				
		<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___				
		<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___				
		<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___				
		<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___				

Race: *Indicate Primary Race (1) & Secondary Race (2)	Ethnicity:	Gender:
American Indian / Alaska Native (AI / AN) Asian (A) Black / African American (B / AA) Native Hawaiian / Other Pacific Islander (NH/PI) White (W) Client doesn't know (DK) Client refused (CR)	Non-Hispanic / Non-Latino (N) Hispanic / Latino (H/L) Client doesn't know (DK) Client refused (CR)	Female (F) Male (M) Trans Female - Male to Female (MTF) Trans Male - Female to Male (FTM) Gender Non-Conforming (GNC) Client doesn't know (DK) Client refused (CR)

Disabling Conditions	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, Long-Continued and Indefinite Duration?			
	Yes	No	Doesn't Know	Refused		Yes	No	Doesn't Know	Refused
Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, Long-Continued and Indefinite Duration?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Both Alcohol & Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Health Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Health Insurance (Check all that apply.)	Is the client covered by health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Refused			
<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> State Children's Health Insurance Program	<input type="checkbox"/> Veteran's Administration Medical Services <input type="checkbox"/> Employer-Provided Health Insurance <input type="checkbox"/> Health Insurance through COBRA	<input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Other: _____		

**Prior Living Situation**  
 Select **only one living situation** below (Homeless Situation, Institutional Situation, OR Temporary and Permanent Housing Situation), then complete the corresponding fields in the table.

<input type="checkbox"/> <b>Homeless Situation</b>	<input type="checkbox"/> Place not meant for habitation <input type="checkbox"/> Emergency shelter (ES), including hotel or motel paid for with ES voucher, or RHY-funded Host Home shelter		
	How long have you been in this current Homeless Situation?	<input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week +, but less than a month	<input type="checkbox"/> One month +, but less than 90 days <input type="checkbox"/> 90 + days, but less than one year <input type="checkbox"/> One year or longer

If this option is selected, you must not select Institutional Situation or Temporary or Permanent Housing Situation	The <b>Approximate Date</b> that the client's current episode of homelessness started is the first date the client started living on the streets or in Emergency Shelter after staying in <b>1) an Institutional Situation for 90+ nights, or 2) a Temporary or Permanent Housing Situation for 7+ nights.</b> <b>If today is their first night in shelter after a break in homelessness, enter today's date.</b>	<b>Approximate Date Homeless Situation started:</b> ____/____/____
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<input type="checkbox"/> <b>Institutional Situation</b>  If this option is selected, you must not select Homeless Situation or Temporary or Permanent Housing Situation	<input type="checkbox"/> Foster care home / group home <input type="checkbox"/> Hospital / non-psychiatric residential medical facility <input type="checkbox"/> Jail/prison/juvenile detention facility	<input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital / psychiatric facility <input type="checkbox"/> Substance abuse treatment facility/detox center	
	How long have you been in this current Institutional Situation?	<input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week +, but less than a month	<input type="checkbox"/> One month +, but less than 90 days <input type="checkbox"/> 90 + days, but less than one year <input type="checkbox"/> One year or longer
	If the stay was less than 90 days, on the night before entering the Institutional Situation, were you on the streets or in ES?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
The <b>Approximate Date</b> that the client's current episode of homelessness started is the first date the client started living on the streets or in Emergency Shelter after staying in an Institutional Situation for 90+ nights. <b>If today is their first night in shelter after a break in homelessness, enter today's date.</b>	<b>Approximate Date Homeless Situation started:</b> ____/____/____		

<input type="checkbox"/> <b>Temporary or Permanent Housing Situation</b>  If this option is selected, you must not select Homeless Situation or Institutional Situation	<input type="checkbox"/> Residential project/halfway house w/ no homeless criteria <input type="checkbox"/> Hotel/motel paid for without ES voucher <input type="checkbox"/> Transitional housing for homeless persons youth <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Staying/living in friend's room/apt./house <input type="checkbox"/> Staying/living in family's room/apt./house <input type="checkbox"/> Rental by client, GPD TIP subsidy <input type="checkbox"/> Rental by client, VASH subsidy	<input type="checkbox"/> Perm. Housing (no RRH) for formerly homeless persons <input type="checkbox"/> Rental by client w/ RRH or equivalent subsidy <input type="checkbox"/> Rental by client w/ HCV voucher (tenant/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, ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Owned by client, ongoing housing subsidy	
	How long have you been in this current Temp. or Perm. Housing Situation?	<input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week +, but less than a month	<input type="checkbox"/> One month +, but less than 90 days <input type="checkbox"/> 90 + days, but less than one year <input type="checkbox"/> One year or longer
	If the stay was less than 7 nights, on the night before entering the Temp. or Perm. Housing Situation, were you on the streets or in ES?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
The <b>Approximate Date</b> that the client's current episode of homelessness started is the first date the client started living on the streets or in Emergency Shelter after staying in a Temporary or Permanent Housing Situation for 7+ nights. <b>If today is their first night in shelter after a break in homelessness, enter today's date.</b>	<b>Approximate Date Homeless Situation started:</b> ____/____/____		

Regardless of where you stayed last night, <b>how many times</b> have you been on the streets or in emergency shelter in the last 3 years? Select one. <input type="checkbox"/> One time <input type="checkbox"/> Three times <input type="checkbox"/> Two times <input type="checkbox"/> Four + times	<b>How many months</b> have you been on the streets or in emergency shelter in the last 3 years? Select one. <input type="checkbox"/> 1 - 12 months (specify): _____ <input type="checkbox"/> More than 12 months
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<b>Monthly Income</b> (Check all that apply.)	Does the client have a source of income? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Refused																												
If yes, what is the total monthly income? \$ _____	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;"><input type="checkbox"/> Alimony/Other spousal support</td> <td style="width:5%; text-align: right;">\$</td> <td style="width:50%;"><input type="checkbox"/> SSDI</td> <td style="width:5%; text-align: right;">\$</td> </tr> <tr> <td><input type="checkbox"/> VA service connected disability compensation</td> <td style="text-align: right;">\$</td> <td><input type="checkbox"/> SSI</td> <td style="text-align: right;">\$</td> </tr> <tr> <td><input type="checkbox"/> VA non-service connected disability pension</td> <td style="text-align: right;">\$</td> <td><input type="checkbox"/> General assistance</td> <td style="text-align: right;">\$</td> </tr> <tr> <td><input type="checkbox"/> Worker's Compensation</td> <td style="text-align: right;">\$</td> <td><input type="checkbox"/> Unemployment insurance</td> <td style="text-align: right;">\$</td> </tr> <tr> <td><input type="checkbox"/> Retirement income from social security</td> <td style="text-align: right;">\$</td> <td><input type="checkbox"/> TANF</td> <td style="text-align: right;">\$</td> </tr> <tr> <td><input type="checkbox"/> Pension/Retirement income from another job</td> <td style="text-align: right;">\$</td> <td><input type="checkbox"/> Child support</td> <td style="text-align: right;">\$</td> </tr> <tr> <td><input type="checkbox"/> Private disability insurance</td> <td style="text-align: right;">\$</td> <td><input type="checkbox"/> Earned income</td> <td style="text-align: right;">\$</td> </tr> </table>	<input type="checkbox"/> Alimony/Other spousal support	\$	<input type="checkbox"/> SSDI	\$	<input type="checkbox"/> VA service connected disability compensation	\$	<input type="checkbox"/> SSI	\$	<input type="checkbox"/> VA non-service connected disability pension	\$	<input type="checkbox"/> General assistance	\$	<input type="checkbox"/> Worker's Compensation	\$	<input type="checkbox"/> Unemployment insurance	\$	<input type="checkbox"/> Retirement income from social security	\$	<input type="checkbox"/> TANF	\$	<input type="checkbox"/> Pension/Retirement income from another job	\$	<input type="checkbox"/> Child support	\$	<input type="checkbox"/> Private disability insurance	\$	<input type="checkbox"/> Earned income	\$
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<input type="checkbox"/> Private disability insurance	\$	<input type="checkbox"/> Earned income	\$																										

Client Name: \_\_\_\_\_ Client DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>Non-Cash Benefits</b> (Check all that apply.)	<b>Does the client receive non-cash benefits?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Refused	
<input type="checkbox"/> TANF Child Care Services	<input type="checkbox"/> Other TANF-Funded Services	<input type="checkbox"/> Special Supp. Nutrition Program for WIC
<input type="checkbox"/> TANF Transportation Services	<input type="checkbox"/> SNAP (Food Stamps)	<input type="checkbox"/> Other (specify): _____

<b>Domestic Violence Victim / Survivor</b>	Victim or survivor of DV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Client refused
<b>If yes, when did the last experience occur?</b>	<b>If yes, is the client currently fleeing?</b>
<input type="checkbox"/> Within last 3 months <input type="checkbox"/> 6-12 months ago <input type="checkbox"/> 1+ years ago <input type="checkbox"/> Doesn't know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't know <input type="checkbox"/> No <input type="checkbox"/> Client refused