|  |  |  |  |
| --- | --- | --- | --- |
| **\*Project Enrollment Date**: |  | **Project Name:** |  |

\*For **ES/TH/PSH Projects** this is the first date of occupancy in the project.

\*For **RRH & Non-Residential Projects**, this is the date the client began receiving services

|  |  |  |  |
| --- | --- | --- | --- |
| **Head of Household**: |  | **Staff Completing Intake**: |  |

Complete a separate form for each Child. [All Clients = Adults & Children]

**Please carefully READ the instructions before answering these questions.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CURRENT NAME** [*All Clients]* | | | | | | | | | | | | | | | | | | | | **N/A** |
| Last | |  |  |  |  |  |  |  |  |  | |  |  | |  |  |  |  |  |  |
| First | |  |  |  |  |  |  |  |  |  | |  |  | |  |  |  |  |  |  |
| Middle | |  |  |  |  |  |  |  |  |  | |  |  | |  |  |  |  |  |  |
| Suffix | |  |  |  |  |  |  |  |  |  | |  |  | |  |  |  |  |  |  |
| Alias | |  |  |  |  |  |  |  |  |  | |  |  | |  |  |  |  |  |  |
| **QUALITY OF CURRENT NAME** *[All Clients]* | | | | | | | | | | | | | | | | | | | | |
|  | Full name reported | | | | | | | | | |  | | | Client doesn’t know | | | | | | |
|  | Partial, street name, or code name reported | | | | | | | | | |  | | | Client refused | | | | | | |

**SOCIAL SECURITY NUMBER** *[All Clients]*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | |  |  | *-* |  |  | *-* |  |  |  | | |  |  |
| **QUALITY OF SOCIAL SECURITY** | | | | | | | | | | | | | | |
|  | Full SSN reported | | | | | | | | | |  | Client doesn’t know | | |
|  | Approximate or partial SSN reported | | | | | | | | | |  | Client refused | | |

**DATE OF BIRTH** *[All Clients]*

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | |  | *-* |  |  | *-* |  |  |  |  |
| Month | | | | *Day* | | | *Year* | | | |
| **QUALITY OF DATE OF BIRTH** | | | | | | | | | | | | | |
|  | Full DOB reported | | | | | | | | | | |  | Client doesn’t know |
|  | Approximate or partial DOB reported | | | | | | | | | | |  | Client refused |

**GENDER** *[All Clients]*

|  |  |  |  |
| --- | --- | --- | --- |
|  | Female |  | Transgender female to male |
|  | Male |  | Client doesn’t know |
|  | Transgender male to female |  | Client refused |
|  | Doesn’t Identify As Male, Female, Or Transgender | | |

**RACE** (select ALL that apply) *[All Clients]*

|  |  |  |  |
| --- | --- | --- | --- |
|  | White |  | Native Hawaiian or Other Pacific Islander |
|  | Black or African American |  | Client doesn’t know |
|  | Asian |  | Client refused |
|  | American Indian or Alaskan Native | | |

**ETHNICITY** *[All Clients]*

|  |  |  |  |
| --- | --- | --- | --- |
|  | Non-Hispanic Non-Latino |  | Client doesn’t know |
|  | Hispanic/Latino |  | Client refused |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Zip Code of Last Permanent Address** *[All Clients]* | | | |  |
|  | Full ZIP reported |  | Client doesn’t know | |
|  | Approximate or partial ZIP reported |  | Client refused | |

|  |  |
| --- | --- |
| **Language** (Primary Language Spoken) |  |

**RELATIONSHIP TO HEAD OF HOUSEHOLD** *[All Clients]*

|  |  |  |
| --- | --- | --- |
|  | | Self (Head of the Household) |
|  | **Head of Household’s Child** | | |
|  | **Head of Household’s Spouse or Partner** | | |
|  | **Head of Household’s Other Relation Member** | | |
|  | **Other: Non-Relation Member** | | |

**ENROLLMENT**

**HOUSING STATUS AT ENTRY** *[ALL Clients]*

*Please review the description of all categories in* ***HMIS Data Standards Manual*** *before responding.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Category 1 – Homeless (Client slept in an Emergency Shelter or Place Not Meant For Habitation) | | |  | Stably Housed |
|  | Category 2 - At Imminent Risk of Losing Housing |  | At-risk of homelessness |  | Data Not Collected |
|  | Fleeing domestic violence |  | Client Doesn’t Know |  | Client Refused |

**RESIDENTIAL MOVE-IN DATE (ESG and RRH Programs *ONLY*)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| HAS THE CLIENT MOVED INTO PERMANENT HOUSING? | | | |  | | No | | | |  | | Yes | | |
| If “YES”, Date Of Residential Move-In: |  |  | / | |  | |  | / |  | |  | |  |  |

**Pregnant**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Yes |  | No |  | Doesn’t Know |  | Refused |  | N/A | *If “YES” Expected Due Date:* |  |

**DISABLING CONDITIONS AND BARRIERS**

**PHYSICAL DISABILITY** *[All Clients]*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | No |  | Client doesn’t know | | | | |
|  | Yes |  | Client refused | | | | |
| **IF “YES” TO PHYSICAL DISABILITY – SPECIFY** | | | | | | | |
| Receiving services for physical disability | | | |  | No |  | Client doesn’t know |
|  | Yes |  | Client refused |
| Is the physical disability expected to be of long-continued and indefinite duration and substantially impairs ability to live independently. | | | |  | No |  | Client doesn’t know |
|  | Yes |  | Client refused |
| **Documentation of the disability and severity on file** | | | |  | No |  | Yes |

**DEVELOPMENTAL DISABILITY** *[All Clients]*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | No |  | Client doesn’t know | | | | |
|  | Yes |  | Client refused | | | | |
| **IF “YES” TO DEVELOPMENTAL DISABILITY – SPECIFY** | | | | | | | |
| Receiving services for developmental disability | | | |  | No |  | Client doesn’t know |
|  | Yes |  | Client refused |
| Is the developmental disability expected to substantially impair ability to live independently? | | | |  | No |  | Client doesn’t know |
|  | Yes |  | Client refused |
| **Documentation of the disability and severity on file** | | | |  | No |  | Yes |

**CHRONIC HEALTH CONDITION** *[All Clients]*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | No |  | Client doesn’t know | | | | | |
|  | Yes |  | Client refused | | | | | |
| **IF “YES” TO CHRONIC HEALTH CONDITION – SPECIFY** | | | | | | | | |
| Currently receiving services/treatment for this condition | | | |  | No |  | | Client doesn’t know |
|  | Yes |  | | Client refused |
| Is the condition expected to be of long-continued and indefinite duration and substantially impairs ability to live independently. | | | |  | No |  | | Client doesn’t know |
|  | Yes |  | | Client refused |
| **Documentation of the disability and severity on file** | | | |  | No |  | Yes | |

**HIV-AIDS** *[All Clients]*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | No |  | Client doesn’t know | | | | |
|  | Yes |  | Client refused | | | | |
| **IF “YES” TO HIV-AIDS – SPECIFY** | | | | | | | |
| Currently receiving services/treatment for this condition | | | |  | No |  | Client doesn’t know |
|  | Yes |  | Client refused |
| Is the condition expected to substantially impair ability to live independently? | | | |  | No |  | Client doesn’t know |
|  | Yes |  | Client refused |
| **Documentation of the disability and severity on file** | | | |  | No |  | Yes |

**MENTAL HEALTH PROBLEMS** *[All Clients]*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | No |  | Client doesn’t know | | | | | |
|  | Yes |  | Client refused | | | | | |
| **IF “YES” TO MENTAL HEALTH PROBLEMS – SPECIFY** | | | | | | | | |
| Currently receiving services/treatment for this condition | | | |  | No |  | Client doesn’t know | |
|  | Yes |  | Client refused | |
| Is the condition expected to be of long-continued and indefinite duration and substantially impairs ability to live independently. | | | |  | No |  | | Client doesn’t know |
|  | Yes |  | | Client refused |
| **Documentation of the disability and severity on file** | | | |  | No |  | | Yes |

**SUBSTANCE ABUSE PROBLEMS** *[All Clients]*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | No |  | Both alcohol and drug abuse | | | | |
|  | Alcohol abuse |  | Client doesn’t know | | | | |
|  | Drug abuse |  | Client refused | | | | |
| **IF “YES” TO ALCOHOL ABUSE, DRUG ABUSE OR BOTH – SPECIFY** | | | | | | | |
| Currently receiving services/treatment for this condition | | | |  | No |  | Client doesn’t know |
|  | Yes |  | Client refused |
| Is the condition expected to be of long-continued and indefinite duration and substantially impairs ability to live independently. | | | |  | No |  | Client doesn’t know |
|  | Yes |  | Client refused |
| **Documentation of the disability and severity on file** | | | |  | No |  | Yes |

**DISABLING CONDITION** *[All Clients] (See Definition Below)*

|  |  |  |  |
| --- | --- | --- | --- |
|  | No |  | Client doesn’t know |
|  | Yes |  | Client refused |

**DISABLING CONDITION** *[All Clients] This data element is to be used with other information to identify whether a client meets the criteria for chronic homelessness. Record whether the client has a disabling condition based on one or more of the following:*

*• A physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury that:*

*(1) Is expected to be long-continuing or of indefinite duration;*

*(2) Substantially impedes the individual's ability to live independently; and*

*(3) Could be improved by the provision of more suitable housing conditions.*

*• A developmental disability, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002); or*

* *The disease of acquired immunodeficiency syndrome (AIDS) or any condition arising from the etiologic agency for acquired immunodeficiency syndrome (HIV).*

**COVERED BY HEALTH INSURANCE** *[All Clients]*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | No |  | Client doesn’t know | | | |
|  | Yes |  | Client refused | | | |
| **IF “YES” TO HEALTH INSURANCE - HEALTH INSURANCE COVERAGE DETAILS** | | | | | | |
|  | MEDICAID (aka Medi-Cal) | | |  | Obtained through COBRA | |
|  | MEDICARE | | |  | Private Pay Health Insurance | |
|  | VA Medical | | |  | Indian Health Services Program | |
|  | Employer Provided | | |  | Other: (Specify) |  |

**EMPLOYMENT**

*[All Clients,* ***For Age 16 & Over****]*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **IS CLIENT EMPLOYED** | | | | |
|  | No |  | Client doesn’t know | |
|  | Yes |  | Client refused | |
| **If “Yes” To Employed** | | | | |
|  | Permanent |  | Client Doesn’t Know | |
|  | Temporary |  | Client Refused | |
|  | Seasonal | Hours Worked Last Week: | |  |
| **If “No” To Employed – Are You Seeking Employment?** | | | | |
|  | Yes |  | Client Doesn’t Know | |
|  | No |  | Client Refused | |

**EDUCATION**

*[All Clients,* ***For Age 5 & over****]*

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **IS CLIENT CURRENTLY ENROLLED IN SCHOOL** | | | | | | | | | | | |
|  | | Yes | |  | | Client doesn’t know | | | | | |
|  | | No | |  | | Client refused | | | | | |
| **Highest Educational Level Completed:** | | | | | | | | | | | |
|  | No School Completed | | | |  | | 10th Grade | | |  | Postsecondary School |
|  | Nursery School to 4th Grade | | | |  | | 11th Grade | | |  | Client Doesn’t Know |
|  | 5th or 6th Grade | | | |  | | 12th Grade, No Diploma | | |  | Client Refused |
|  | 7th or 8th Grade | | | |  | | High School Diploma | | |  |  |
|  | 9th Grade | | | |  | | GED | | |  |  |
| **Name of School Enrolled:** | | |  | | | | | | | | |
| **Type of School:** | | |  | | Public | | |  | Parochial or Other Private School | | |
| **Is Child Connected To The Homeless Liaison?** | | | | | | | | | | | |
|  | | Yes | |  | | Client doesn’t know | | | | | |
|  | | No | |  | | Client refused | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **IF NOT ENROLLED** | | | | |
| Date Of Their Last Enrollment: | | |  | |
| **Barrier To Enrolling Child In School:**  **:** | | | | |
|  | None |  | | Lack Of An Available Preschool Program | |
|  | Residency Requirements |  | | Immunization Requirements | |
|  | Availability Of School Records |  | | Physical Examination Records | |
|  | Birth Certificate |  | | Other | |
|  | Legal Guardianship Required |  | | Don’t Know | |
|  | Transportation |  | | Refused | |