CW HMIS Individual Intake

Project Start Date: ___________________ **(Permanent Housing Clients only): Housing Move-in Date:**________________
(Indicate the date on which the client achieved placement in permanent housing.)

Applicant (Head of Household) Information:

First Name: ____ **Last Name**: ____

Middle Name: ____ **Suffix**: ____

Name Data Quality: ☐ Full Name Reported ☐ Partial, Street Name, or Code Name reported ☐ Client Doesn't Know ☐ Client Refused

Date of Birth: _________/_______/_________ ☐ Full DOB Reported ☐ Approximate or Partial DOB Reported ☐ Client Doesn't Know ☐ Client Refused

Social Security Number: __________-________-__________ ☐ Full SSN Reported ☐ Approximate or Partial SSN Reported ☐ Client Doesn't Know ☐ Client Refused

Gender: ☐ Male ☐ Female ☐ Tran Female (MTF or Male to Female) ☐ Trans Male (FTM or Female to Male) ☐ Gender Non-Conforming (i.e. not exclusively male or female ☐ Client Doesn't Know ☐ Client Refused

Primary Language: ☐ English ☐ Spanish ☐ French ☐ Portuguese ☐ Other ☐ Client Doesn't Know If Other, please specify: _______________________

Relationship to HOH: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Grandparent ☐ Guardian ☐ Other Relative ☐ Other Non-Relative ☐ Grandchild ☐ Foster-Child

Race: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian/ Pacific Islander ☐ Client Doesn't Know ☐ Client Refused

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Client Doesn't Know ☐ Client Refused

Veteran Status: Have you ever been on active duty in the U.S. Military? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

Address: ____

Cell Phone: ___________________________ **Work Phone:** ___________________________ **Email:** ____

Home Phone: _________________________

Client Location (CoC): ____

Disabling Condition: ☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused

Type of Residence: Identify the type of living situation and length of stay in that situation just prior to project start for all adults and heads of households.

HOMELESS SITUATION

☐ Emergency Shelter or hotel / motel paid with ES voucher
☐ Place not meant for human habitation
☐ Safe Haven
☐ Interim Housing

INSTITUTIONAL SITUATION

☐ Foster care 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

TRANSITIONAL & PERMANENT HOUSING SITUATION

☐ Hotel / Motel paid without ES voucher
☐ Owned by client, no ongoing housing subsidy
☐ Owned by client, with ongoing housing subsidy
☐ Permanent housing (other than RRH) for formerly homeless persons
☐ Rental by client no ongoing housing subsidy
☐ Rental by client, with other ongoing housing subsidy (including RRH)
☐ Staying or living in a family, member's room, apartment or house
☐ Transitional housing for homeless persons
☐ Rental by client, with GPD TID housing subsidy
☐ Residential project or halfway house with no homeless
☐ Client doesn't know
☐ Client refused

If Type of Residence is a ***HOMELESS SITUATION***: **Approximate Date Homelessness Started: _______/________/_________**

If Type of Residence is an ***INSTITUTIONAL SITUATION***, the questions below are required**:**

Did you stay less than 90 days? ☐ Yes ☐ No

If Yes, **On the night before did you stay on the streets, ES or SH**: ☐ Yes ☐ No

If Type of Residence is a ***TRANSITIONAL or PERMANENT HOUSING SITUATION***, the question below is required**:**

Did you stay less than 7 nights? ☐ Yes ☐ No

If Yes, **On the night before did you stay on the streets, ES or SH:** ☐ Yes ☐ No

Length of Stay in the Prior Living Situation

☐ One night or less
☐ Two days 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

(Regardless of where they stayed last night): Number of Times the Client Has Been Homeless on the Streets, in ES, or SH in the Past Three Years Including Today:

☐ Never in 3 Years ☐ One Time ☐ Two Times ☐ Three Times ☐ Four or More Times ☐ Client doesn't know ☐ Client refused

Total Number of Months Homeless on the Streets, in ES, or SH in the Past Three Years:

☐ One Month (this time is the first month)
☐ 2-12 Months (Specify # of Months: ______)
☐ More than 12 months
☐ Client Doesn't Know

Domestic Violence Survivor? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
If "YES" When experience occurred?

☐ Within the past three months
☐ Three to six months ago (excluding six months exactly)
☐ Six months to one year ago (excluding one year exactly)
☐ One year ago, or more
☐ Client doesn't know
☐ Client refused

If "YES" Are you currently fleeing? ☐ Yes ☐ No ☐ Don't Know ☐ Refused

Non-cash benefit from any source? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
If yes, Non-cash benefit source is required. **Check those that apply:**

☐ Supplemental Nutrition Assistance Program (SNAP) (Previously known as Food Stamps)
☐ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
☐ TANF Child Care Services
☐ TANF Transportation services
☐ Other TANF-funded services
☐ Other Source, specify if Other:______________________________

Covered by Health Insurance: ☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused

Disabling Conditions:
Substance Abuse: ☐ No ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol and Drug Abuse ☐ Client doesn't know ☐ Client refused ☐ Data Not Collected
If yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? ☐ No ☐ Yes ☐ Client doesn't know ☐ Client refused ☐ Data Not Collected
Physical Disability: ☐ No ☐ Yes ☐ Client doesn't know ☐ Client refused ☐ Data Not Collected
If yes, 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 Disability: ☐ No ☐ Yes ☐ Client doesn't know ☐ Client refused ☐ Data Not Collected
If yes, Expected to substantially impair ability to live independently? ☐ No ☐ Yes ☐ Client doesn't know ☐ Client refused ☐ Data Not Collected
Chronic Health Condition: ☐ No ☐ Yes ☐ Client doesn't know ☐ Client refused ☐ Data Not Collected
If yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? ☐ No ☐ Yes ☐ Client doesn't know ☐ Client refused ☐ Data Not Collected
HIV/AIDS: ☐ No ☐ Yes ☐ Client doesn't know ☐ Client refused ☐ Data Not Collected
If yes, Expected to substantially impair ability to live independently? ☐ No ☐ Yes ☐ Client doesn't know ☐ Client refused ☐ Data Not Collected
Mental Health Problem: ☐ No ☐ Yes ☐ Client doesn't know ☐ Client refused ☐ Data Not Collected
If yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? ☐ No ☐ Yes ☐ Client doesn't know ☐ Client refused ☐ Data Not Collected

Income received from any source? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

Income Type	Monthly Amount	Income Type	Monthly Amount
Unemployment Insurance	☐ N ☐ Y $	VA Non-Service-Connected Disability Pension	☐ N ☐ Y $
Earned/Employed Income	☐ N ☐ Y $	Pension or Retirement income from a former job	☐ N ☐ Y $
Supplemental Security Income (SSI)	☐ N ☐ Y $	Child Support	☐ N ☐ Y $
Social Security Disability Insurance (SSDI)	☐ N ☐ Y $	Alimony or other spousal support	☐ N ☐ Y $
VA Service-Connected Disability Compensation	☐ N ☐ Y $	Worker's Compensation	☐ N ☐ Y $
Private Disability Insurance	☐ N ☐ Y $	Other Source Specify:	☐ N ☐ Y $
Retirement Income From Social Security	☐ N ☐ Y $		
General Assistance (GA)	☐ N ☐ Y $		
Temporary Assistance for Needy Families (TANF)	☐ N ☐ Y $	**Client Income Total**	$

Health Insurance (select which applies):

☐ MEDICAID
☐ MEDICARE
☐ State Children's Health Insurance Program
☐ Veteran's Administration (VA) Medical Service
☐ Employer-Provided Health Insurance
☐ Health Insurance obtained through COBRA
☐ State Health Insurance for Adults
☐ Private Pay Health Insurance
☐ Indian Health Services Program
☐ Other
If Other, Specify: ______________________________

Veteran Information:

DD214 Order Date: ___________/______________/______________ **DD214 Receive Date:** __________/______________/____________

Service Connected Disability: ☐ Yes ☐ No

***Branch of military:** ☐ Air Force ☐ Army ☐ Marines ☐ Navy ☐ Coast Guard ☐ Client Doesn't Know ☐ Client Refused ☐ Other

Reserves: ☐ Yes ☐ No

***Discharge status:** ☐ Honorable ☐ General under Honorable Conditions ☐ Under Other than Honorable Conditions ☐ Bad Conduct ☐ Dishonorable ☐ Uncharacterized ☐ Don't Know ☐ Refused

***Date Entered Service:** ___________/____________/______________ ***Date Separated Service:** _________/______________/____________

Months of Active Duty: _______________________________ **Campaign Badge Veteran:** ☐ Yes ☐ No

Stand Down Event: ☐ Yes ☐ No

Serve in a War Zone: ☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused

If YES, please select the **War Zone Name**: ☐ Afghanistan ☐ China, Burma, India ☐ Don't Know ☐ Europe ☐ Iraq ☐ Korea ☐ Laos and Cambodia ☐ North Africa ☐ Other ☐ Persian Gulf ☐ Refused ☐ South China Sea ☐ South Pacific ☐ Vietnam

***Months Served in a Warzone:** ______________________ ***If Yes, Received Friendly or Hostile Fire:** ___________________

***Theatre of Operations:** ☐ World War II ☐ Korean War ☐ Vietnam War ☐ Persian Gulf War (Operation Desert Storm) ☐ Afghanistan (Operation Enduring Freedom) ☐ Iraq (Operation Iraqi Freedom) ☐ Iraq (Operation New Dawn) ☐ Other Peace-keeping Operations or Military Interventions

Additional notes:

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