

# HMIS INTAKE Data Collection Form for Solano County Projects

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## General Instructions

This is the entry form for ALL projects in Solano County except for PATH, RHY, and VA programs. This form should be filled out for all household members and entered into HMIS accordingly.

Income and benefits collected by minor children in the household should be reported under the head of household. If a household presents as two minor youth, one of the youth should be designated as the head of household.

No question should remain blank at the end of the assessment. The administrator of this intake must ask all questions of the client and mark the appropriate response. Please note that current HMIS policies require that all data be entered into HMIS within three days of acquisition.

If you are confused about how to answer a question, please refer to the HMIS Data Dictionary. If the data dictionary does not answer your question, please reach out to [solanoHMIS@homebaseccc.org](mailto:solanoHMIS@homebaseccc.org) for assistance.

**CLIENT NAME:**

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**DATE ADMINISTERED:**

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## CLIENT RECORD

### NAME

In HMIS the “name” field will be created upon record entry and should auto-populate into the Entry Assessment. Use a client’s full, legal name whenever possible. Generally, projects do not need to verify that the information provided matches legal documents.

First name \_\_\_\_\_ Middle name(s) \_\_\_\_\_

Last name \_\_\_\_\_ Suffix \_\_\_\_\_ Alias \_\_\_\_\_

### NAME DATA QUALITY

Street outreach projects may record a project start with limited information about the client and improve on the accuracy and completeness of client data over time. If using a “made up name” for such an initial identification, indicate that here.

<input type="checkbox"/> Full name reported	<input type="checkbox"/> Partial, street name, or code name reported	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
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### SOCIAL SECURITY NUMBER AND DATA QUALITY

The Social Security Number is created when the client record is created and should auto-populate into the Entry Assessment. Some projects may serve clients that do not have an SSN. In these cases, select ‘Client doesn’t know.’

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<input type="checkbox"/> Full SSN reported
<input type="checkbox"/> Approximate or partial SSN reported
<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Client refused

### VETERAN STATUS

This element is based on self-report by the client. A veteran is anyone who has ever been on active duty in the armed forces of the United States, regardless of discharge status or length of service. For the **Army, Navy, Air Force, Marine Corps, and Coast Guard**, active duty begins when a military member reports to a duty station after completion of training. For the **Reserves and National Guard**, active duty is any time spent activated or deployed, either in the United States or abroad. Or Anyone who was disabled in the line of duty during a period of active duty training. Or Anyone who was disabled from an injury incurred in the line of duty or from acute myocardial infarction, a cardiac arrest, or a cerebrovascular accident during a period of inactive duty training.

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
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### PROJECT START DATE (e.g., 04/25/2020)

The Project Start Date serves as the information date for all data elements collected on this form; all data must be accurate as of this date, regardless of the date collected.

		/			/			
Month			Day			Year		

## CLIENT DEMOGRAPHICS

### DATE OF BIRTH

Use 01/01/YEAR and select 'approximate or partial date of birth' if client cannot recall DOB.

		/			/			
Month			Day			Year		

### DATE OF BIRTH DATA QUALITY

<input type="checkbox"/>	Full date of birth reported
<input type="checkbox"/>	Approximate or partial date of birth reported
<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Client refused

### GENDER

<input type="checkbox"/>	Female	<input type="checkbox"/>	Questioning
<input type="checkbox"/>	Male	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	A gender that is not singularly female or male (e.g. non-binary, genderfluid, agender, culturally specific gender)	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Transgender		

### RACE

Clients may report up to two different races. If a client only identifies as one racial category leave the "secondary race" field blank. "Client doesn't know" and "Client refused" should only be selected if no other response is selected. If the client wishes to indicate "Hispanic or Latino," please indicate that in Ethnicity and then select the appropriate race category here.

	Primary race	Secondary race
American Indian or Alaska Native, or Indigenous	<input type="checkbox"/>	<input type="checkbox"/>
Asian or Asian American	<input type="checkbox"/>	<input type="checkbox"/>
Black, African American, or African	<input type="checkbox"/>	<input type="checkbox"/>
Native Hawaiian or Pacific Islander	<input type="checkbox"/>	<input type="checkbox"/>
White	<input type="checkbox"/>	<input type="checkbox"/>
Client doesn't know	<input type="checkbox"/>	<input type="checkbox"/>
Client refused	<input type="checkbox"/>	<input type="checkbox"/>

### ETHNICITY

<input type="checkbox"/>	Non-Hispanic/Non-Latin(a)(o)(x)	<input type="checkbox"/>	Hispanic/Latin(a)(o)(x)	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused
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### RELATIONSHIP TO HEAD OF HOUSEHOLD

In a household of a single individual, that person must be identified as the head of household. In multi-person households, one of person must be designated as the head of household and the rest must have their relationship to the head of household recorded. If the group of persons is composed of adults and children, an adult must be indicated as the head of household.

<input type="checkbox"/>	Self (head of household)	<input type="checkbox"/>	Head of household's other relation member (other relation to head of household)
<input type="checkbox"/>	Head of household's child	<input type="checkbox"/>	Other: non-relation member
<input type="checkbox"/>	Head of household's spouse or partner		

## CLIENT DEMOGRAPHICS (CONTINUED)

### PRIMARY LANGUAGE

<input type="checkbox"/>	American Sign Language	<input type="checkbox"/>	French	<input type="checkbox"/>	Lao	<input type="checkbox"/>	Thai
<input type="checkbox"/>	Arabic	<input type="checkbox"/>	German	<input type="checkbox"/>	Mandarin	<input type="checkbox"/>	Vietnamese
<input type="checkbox"/>	Armenian	<input type="checkbox"/>	Hindi	<input type="checkbox"/>	Portuguese	<input type="checkbox"/>	Other
<input type="checkbox"/>	Austronesian	<input type="checkbox"/>	Hmong	<input type="checkbox"/>	Punjabi	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Cantonese	<input type="checkbox"/>	Japanese	<input type="checkbox"/>	Russian	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	English	<input type="checkbox"/>	Khmer	<input type="checkbox"/>	Spanish		
<input type="checkbox"/>	Farsi	<input type="checkbox"/>	Korean	<input type="checkbox"/>	Tagalog		

If **OTHER**, specify: \_\_\_\_\_

### EDUCATION

What is the client's highest level of educational attainment?

<input type="checkbox"/>	Less than grade 5	<input type="checkbox"/>	Some college
<input type="checkbox"/>	Grades 5–6	<input type="checkbox"/>	Associate degree
<input type="checkbox"/>	Grades 7–8	<input type="checkbox"/>	Bachelor's degree
<input type="checkbox"/>	Grades 9–11	<input type="checkbox"/>	Graduate degree
<input type="checkbox"/>	Grade 12 or high school diploma	<input type="checkbox"/>	Vocational certification
<input type="checkbox"/>	School program does not have grade levels	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	GED	<input type="checkbox"/>	Client refused

### SEXUAL ORIENTATION

<input type="checkbox"/>	Heterosexual	<input type="checkbox"/>	Lesbian	<input type="checkbox"/>	Questioning or unsure	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Gay	<input type="checkbox"/>	Bisexual	<input type="checkbox"/>	Other	<input type="checkbox"/>	Client refused

If **OTHER**, specify: \_\_\_\_\_

### PHOTO ID

Does the client have a valid driver's license or photo identification?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused
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## CURRENT LIVING SITUATION

### START DATE

		/			/				
Month			Day			Year			

### END DATE

		/			/				
Month			Day			Year			

### INFORMATION DATE

		/			/				
Month			Day			Year			

### CURRENT LIVING SITUATION

<input type="checkbox"/>	Place not meant for habitation	<input type="checkbox"/>	Rental by client, with GPD TIP housing subsidy
<input type="checkbox"/>	Emergency shelter, including hotel or motel paid for with emergency shelter voucher or RHY-funded Host Home shelter	<input type="checkbox"/>	Rental by client, with VASH housing subsidy
<input type="checkbox"/>	Safe Haven	<input type="checkbox"/>	Permanent housing (other than RRH) for formerly homeless persons
<input type="checkbox"/>	Foster care home or foster care group home	<input type="checkbox"/>	Rental by client, with RRH of equivalent subsidy
<input type="checkbox"/>	Hospital or other residential non-psychiatric medical facility	<input type="checkbox"/>	Rental by client, with HCV voucher (tenant or project based)
<input type="checkbox"/>	Jail, prison, or juvenile detention facility	<input type="checkbox"/>	Rental by client in a public housing unit
<input type="checkbox"/>	Long-term care facility or nursing home	<input type="checkbox"/>	Rental by client, no ongoing housing subsidy
<input type="checkbox"/>	Psychiatric hospital or other psychiatric facility	<input type="checkbox"/>	Rental by client, with other ongoing housing subsidy
<input type="checkbox"/>	Substance abuse treatment facility or detox center	<input type="checkbox"/>	Owned by client, with ongoing housing subsidy
<input type="checkbox"/>	Residential project or halfway house with no homeless criteria	<input type="checkbox"/>	Owned by client, no ongoing housing subsidy
<input type="checkbox"/>	Hotel or motel paid for without emergency shelter voucher	<input type="checkbox"/>	Other
<input type="checkbox"/>	Transitional housing for homeless persons (including homeless youth)	<input type="checkbox"/>	Worker unable to determine
<input type="checkbox"/>	Host Home (non-crisis)	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Staying or living in a friend's room, apartment or house	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Staying or living in a family member's room, apartment or house		

If **OTHER**, specify: \_\_\_\_\_

## CURRENT LIVING SITUATION (CONTINUED)

### PROVIDER VERIFYING LIVING SITUATION

<input type="checkbox"/>	BayNorth Church of Christ	<input type="checkbox"/>	Mission Samoa
<input type="checkbox"/>	Berkeley Food & Housing Project	<input type="checkbox"/>	Nation's Finest
<input type="checkbox"/>	Caminar, Inc.	<input type="checkbox"/>	Northern California Family Center
<input type="checkbox"/>	Catholic Charities of Yolo-Solano	<input type="checkbox"/>	On the Move
<input type="checkbox"/>	City of Fairfield Homeless Outreach	<input type="checkbox"/>	Resource Connect Solano
<input type="checkbox"/>	City Vallejo Housing Authority	<input type="checkbox"/>	SHELTER, Inc.
<input type="checkbox"/>	Community Action North Bay	<input type="checkbox"/>	Solano County Healthy & Social Services
<input type="checkbox"/>	Edge Community Church	<input type="checkbox"/>	VA of Northern California
<input type="checkbox"/>	Fighting Back Partnership	<input type="checkbox"/>	Vacaville Solano Services
<input type="checkbox"/>	Lutheran Social Services	<input type="checkbox"/>	Volunteers of America

Is the client going to have to leave their current living situation within 14 days?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused
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<i>If YES, please specify.</i>	Yes	No	Client doesn't know	Client refused
Has a subsequent residence been identified?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the client have resources or support networks to obtain other permanent housing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the client had a lease or ownership interest in a permanent housing unit in the last 60 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the client moved two or more times in the last 60 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

LOCATION DETAILS: \_\_\_\_\_

### DATE OF ENGAGEMENT

This field asks when the client was first engaged by the project.

		/			/				
Month			Day			Year			

### CLIENT LOCATION

The only option for client location in HMIS is "CA-518," which corresponds with the Solano Continuum of Care.

## CURRENT LIVING SITUATION (CONTINUED)

### LOCATION WHERE CLIENT SLEPT LAST NIGHT

This field asks for the location where the client slept night. Select the location from a list of cities, census-designated places and unincorporated places in Solano County. If the location where the client slept last night was outside Solano County, select the appropriate county or geographic area.

Location	Location where the client <u>slept last night</u>	Location where the client was <u>last housed</u>
Benicia	<input type="checkbox"/>	<input type="checkbox"/>
Birds Landing	<input type="checkbox"/>	<input type="checkbox"/>
Dixon	<input type="checkbox"/>	<input type="checkbox"/>
Fairfield	<input type="checkbox"/>	<input type="checkbox"/>
Green Valley	<input type="checkbox"/>	<input type="checkbox"/>
Rio Vista	<input type="checkbox"/>	<input type="checkbox"/>
Suisun City	<input type="checkbox"/>	<input type="checkbox"/>
Vacaville	<input type="checkbox"/>	<input type="checkbox"/>
Vallejo	<input type="checkbox"/>	<input type="checkbox"/>
Other area in Solano County	<input type="checkbox"/>	<input type="checkbox"/>
Alameda County	<input type="checkbox"/>	<input type="checkbox"/>
Contra Costa County	<input type="checkbox"/>	<input type="checkbox"/>
Napa County	<input type="checkbox"/>	<input type="checkbox"/>
Sacramento County	<input type="checkbox"/>	<input type="checkbox"/>
San Francisco County	<input type="checkbox"/>	<input type="checkbox"/>
Yolo County	<input type="checkbox"/>	<input type="checkbox"/>
Other area in California (outside Solano County)	<input type="checkbox"/>	<input type="checkbox"/>
Other area outside of California	<input type="checkbox"/>	<input type="checkbox"/>

### HOUSING STATUS

This field asks when the client is actually in housing. It is possible for a client to enter a project prior to actually taking possession of the unit. This is common when the project is providing housing locator services for the client. Provide the date the client actually takes possession of the unit. If the client has not taken possession of the unit at the time of project entry leave this field blank and provide an update at a later time when the unit becomes available.

Is the client in permanent housing of project entry date?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
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If YES, what is the housing move-in date?

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If YES, what is the monthly rent or mortgage?

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# HOMELESS STATUS VERIFICATION

## 1. TYPE OF PRIOR LIVING SITUATION

What was the situation the client was living in immediately prior to project start?

Adult members of the same household may have different prior living situations

Homeless Situations	
<input type="checkbox"/>	Place not meant for habitation
<input type="checkbox"/>	Emergency shelter, including hotel or motel paid for with emergency shelter voucher
<input type="checkbox"/>	Safe Haven
Institutional Situations	
<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
Transitional & Permanent Housing Situations	
<input type="checkbox"/>	Hotel or motel paid for without emergency shelter voucher
<input type="checkbox"/>	Owned by client, no ongoing housing subsidy
<input type="checkbox"/>	Owned by client, with ongoing housing subsidy
<input type="checkbox"/>	Permanent housing (other than RRH) for formerly homeless persons
<input type="checkbox"/>	Rental by client, no ongoing subsidy
<input type="checkbox"/>	Rental by client, with VASH subsidy
<input type="checkbox"/>	Rental by client, with GPD TIP subsidy
<input type="checkbox"/>	Rental by client, with other ongoing housing subsidy
<input type="checkbox"/>	Residential project or halfway house with no homeless criteria
<input type="checkbox"/>	Staying or living in a family member's room, apartment, or house
<input type="checkbox"/>	Staying or living in a friend's room, apartment, or house
<input type="checkbox"/>	Transitional housing for homeless persons (including homeless youth)
Other	
<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Client refused

## 2. LENGTH OF STAY IN PRIOR LIVING SITUATION

How long was the client staying in that place?

If the client moved around, but in the same type of situation, include the total time in that type of situation. If the client moved around from one situation to another, only include the time in the situation selected.

<input type="checkbox"/>	1 night or less
<input type="checkbox"/>	2 to 6 nights
<input type="checkbox"/>	1 week+, but less than 1 month
<input type="checkbox"/>	1 month+, but less than 90 days
<input type="checkbox"/>	90 days, but less than 1 year
<input type="checkbox"/>	1 year or longer
<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Client refused

Proceed to Question 3

<input type="checkbox"/>	1 night or less
<input type="checkbox"/>	2 to 6 nights
<input type="checkbox"/>	1 week+, but less than 1 month
<input type="checkbox"/>	1 month+, but less than 90 days
<input type="checkbox"/>	90 days, but less than 1 year
<input type="checkbox"/>	1 year or longer
<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Client refused

Proceed to Question 3

**STOP**  
Proceed to Disability Status (page 10)

<input type="checkbox"/>	1 night or less
<input type="checkbox"/>	2 to 6 nights
<input type="checkbox"/>	1 week, but less than 1 month
<input type="checkbox"/>	1 month, but less than 90 days
<input type="checkbox"/>	90 days, but less than 1 year
<input type="checkbox"/>	1 year or longer
<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Client refused

**STOP**  
Proceed to Disability Status (page 10)



## HOMELESS STATUS VERIFICATION (CONTINUED)

### 3. DATE THE CLIENT BECAME HOMELESS THIS TIME

#### When did the client start staying on the streets,\* in emergency shelters, or in safe havens this time?

Determine the date of the last time the client had a place to sleep that was not on the streets, in an emergency shelter, or in a safe haven. Breaks in homelessness are allowed to be included in the look back period to calculate the start date only if:

- The client moved continuously between the streets, shelters, or safe havens. The date would go back as far as the first time they stayed in one of those places; OR
- The break in their time on the streets, shelters, or safe havens was less than 7 nights. A break is considered 6 or less consecutive nights not residing in a place not meant for human habitation, in shelter or in a safe haven. The look back time would not be broken by a stay less than 7 consecutive nights; OR
- The break in their time on the streets, ES, or SH was less than 90 days in any of the places listed under the header “institutional situations” on the previous page. The look back time would include all of those days (up to 89 days) when looking back for the start date.

If this is the client’s first day on the streets, shelters, or safe havens, enter today’s date.

\* “The streets” is being used as short-hand for any place unfit for human habitation (a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground).

		/			/				
Month		Day		Year					

### 4. NUMBER OF TIMES THE CLIENT HAS BEEN HOMLESS IN THE PAST THREE YEARS

How many times has the client been homeless on the streets, in shelter, or in safe havens in the past three years, including this time?

Count the times a client has been homeless, separated by breaks, in the last three years. A break means at least 7 consecutive nights of not living on the street, in an emergency shelter, or Safe Haven or at least 90 days in any of the places listed under the header “institutional situations” on the previous page.

<input type="checkbox"/>	One time (this time)	<input type="checkbox"/>	Four or more times
<input type="checkbox"/>	Two times	<input type="checkbox"/>	Client doesn’t know
<input type="checkbox"/>	Three times	<input type="checkbox"/>	Client refused

### 5. TOTAL NUMBER OF MONTHS THE CLIENT HAS BEEN HOMLESS IN THE PAST THREE YEARS

How many months, in total, has the client has been homeless on the street, in an emergency shelter, or Safe Haven over the past three years?

Add the number of months homeless of all the different times the client has spent homeless on the streets, in shelter, or in safe havens in the past three years. Include any time a client spent in an institution for a period of less than 90 days or time spent in permanent or transitional housing for a period of less than 7 days. Responses may be rounded to the next-highest number of full months. The current month, even if a partial month, can be counted as a full month.

<input type="checkbox"/>	One month or less (choose if this is the first time the client has been homeless)		
<input type="checkbox"/>	Between 2 and 12 months →	<b>Enter the total number of months:</b>	
<input type="checkbox"/>	More than 12 months		
<input type="checkbox"/>	Client doesn’t know		
<input type="checkbox"/>	Client refused		

## DISABILITIES

Disability elements for HMIS data collections are based on client report. A client is not required to show proof of disability in order to respond “yes” to this question. Programs which require a disability for a client to be eligible for services may further investigate this element.

### SUBSTANCE USE DISORDER

<input type="checkbox"/>	Yes: Alcohol use disorder <b>only</b>	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes: Drug use disorder <b>only</b>	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Yes: Both alcohol <b>and</b> drug use disorders	<input type="checkbox"/>	Client refused



If **YES** for alcohol use disorder, drug use disorder, or both alcohol and drug use disorder, is the disability expected to be of long-continued and indefinite duration and substantially impairs client's ability to live independently?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused

### IF YES, DISABILITY START DATE

		/			/			
Month			Day			Year		

### NOTE ON DISABILITY

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### CHRONIC HEALTH CONDITION

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know



If **YES** for chronic health condition, is the disability expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused

### IF YES, DISABILITY START DATE

		/			/			
Month			Day			Year		

### NOTE ON DISABILITY

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### DEVELOPMENTAL

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know



If **YES** for developmental disability, is the disability expected to substantially impair the client's ability to live independently?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused

### IF YES, DISABILITY START DATE

		/			/			
Month			Day			Year		

### NOTE ON DISABILITY

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## DISABILITIES (CONTINUED)

### HIV/AIDS

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know



If **YES** for **HIV/AIDS**, is the disability expected to substantially impair the client's ability to live independently?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused

### IF YES, DISABILITY START DATE

		/			/			
Month			Day			Year		

### NOTE ON DISABILITY

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### MENTAL HEALTH DISORDER

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know



If **YES** for **mental health disorder**, is the disability expected to be of long-continued and indefinite duration and substantially impairs the client's ability to live independently?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused

### IF YES, DISABILITY START DATE

		/			/			
Month			Day			Year		

### NOTE ON DISABILITY

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### PHYSICAL

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know



If **YES** for **physical disability**, is the disability expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused

### IF YES, DISABILITY START DATE

		/			/			
Month			Day			Year		

### NOTE ON DISABILITY

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### DISABLING CONDITION

A disabling condition is any of the above-indicated disabilities or any other physical, mental, or emotional impairment (including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury) that is expected to be of long-continued and indefinite duration and substantially impair ability to live independently. **Does the client currently have a disabling condition?**

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Client refused

## INCOME

Record regular, recurrent sources that are current (i.e. not terminated). Income received for a minor member of the household should be recorded under the Head of Household's information. If the client has income, enter the monthly amount received. Answer 'No' for sources that have been terminated, even if they were received in the past.

Does the client have any income from any source?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
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If **YES**, answer 'Yes' or 'No' for each income source.

Source of income	Receiving income from source?		If YES, date client began receiving income	If YES, monthly amount from source (round to nearest dollar)						
Alimony or other spousal support	Yes	<input type="checkbox"/>		\$						. 0 0
	No	<input type="checkbox"/>								
Child support	Yes	<input type="checkbox"/>		\$						. 0 0
	No	<input type="checkbox"/>								
Earned income (i.e., employment income)	Yes	<input type="checkbox"/>		\$						. 0 0
	No	<input type="checkbox"/>								
General Assistance (GA)	Yes	<input type="checkbox"/>		\$						. 0 0
	No	<input type="checkbox"/>								
Pension or retirement income from a former job	Yes	<input type="checkbox"/>		\$						. 0 0
	No	<input type="checkbox"/>								
Private Disability Insurance	Yes	<input type="checkbox"/>		\$						. 0 0
	No	<input type="checkbox"/>								
Retirement Income from Social Security	Yes	<input type="checkbox"/>		\$						. 0 0
	No	<input type="checkbox"/>								
Social Security Disability Insurance (SSDI)	Yes	<input type="checkbox"/>		\$						. 0 0
	No	<input type="checkbox"/>								
Supplemental Security Income (SSI)	Yes	<input type="checkbox"/>		\$						. 0 0
	No	<input type="checkbox"/>								
Temporary Assistance for Needy Families (TANF)	Yes	<input type="checkbox"/>		\$						. 0 0
	No	<input type="checkbox"/>								
Unemployment Insurance	Yes	<input type="checkbox"/>		\$						. 0 0
	No	<input type="checkbox"/>								
VA Non-Service-Connected Disability Pension	Yes	<input type="checkbox"/>		\$						. 0 0
	No	<input type="checkbox"/>								
VA Service-Connected Disability Compensation	Yes	<input type="checkbox"/>		\$						. 0 0
	No	<input type="checkbox"/>								
Worker's Compensation	Yes	<input type="checkbox"/>		\$						. 0 0
	No	<input type="checkbox"/>								
Other source (specify): _____	Yes	<input type="checkbox"/>		\$						. 0 0
	No	<input type="checkbox"/>								
<b>Total monthly income from all sources</b>				\$						. 0 0

What is the client's income as a percentage of Area Median Income (AMI)?

<input type="checkbox"/> < 30%	<input type="checkbox"/> 30–50%	<input type="checkbox"/> > 50%
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Does the client have a connection with SSI/SSDI, Outreach, Access, and Recovery (SOAR)?

<input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> No	<input type="checkbox"/> Client refused

## NON-CASH BENEFITS

Only record regular, recurrent sources that are current (i.e. not terminated). Non-cash benefits received for a minor member of the household should be recorded under the Head of Household's information. Answer 'No' for sources that have been terminated, even if they were received in the past.

Does the client have any non-cash benefits from any source?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
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If **YES**, answer 'Yes' or 'No' for each non-cash benefit source.

Source of Non-Cash Benefit	Receiving source?		If YES, date client began receiving source	If YES, monthly amount from source (round to nearest dollar)								
	Yes	No		\$								
Supplemental Nutrition Assistance Program, (i.e. CalFresh or Food Stamps)	Yes	<input type="checkbox"/>		\$						.	0	0
	No	<input type="checkbox"/>										
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	Yes	<input type="checkbox"/>		\$						.	0	0
	No	<input type="checkbox"/>										
TANF Child Care services	Yes	<input type="checkbox"/>		\$						.	0	0
	No	<input type="checkbox"/>										
TANF Transportation Services	Yes	<input type="checkbox"/>		\$						.	0	0
	No	<input type="checkbox"/>										
Other TANF-Funded Services	Yes	<input type="checkbox"/>		\$						.	0	0
	No	<input type="checkbox"/>										
Other: _____	Yes	<input type="checkbox"/>		\$						.	0	0
	No	<input type="checkbox"/>										

## HEALTH INSURANCE

Only record regular, recurrent sources that are current (i.e. not terminated). Answer 'No' for sources that have been terminated, even if they were received in the past.

Is the client currently covered by health insurance?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
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If **YES**, answer 'Yes' or 'No' for each health insurance source.

Source of Health Insurance	Receiving health insurance source?		If YES, date client began receiving source	For HOPWA, specify private pay insurance source, if applicable	For HOPWA, specify reason not covered, if applicable
Medicaid (i.e. Medi-Cal)	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
Medicare	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
State Children's Health Insurance Program (CHIP)	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
Veteran's Administration (VA) Medical Services	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
Employer-Provided Health Insurance	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
Health insurance obtained through COBRA	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
Private Pay Health Insurance	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
State Health Insurance for Adults	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
Indian Health Services Program	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
Other: _____	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			

## WELL-BEING

<b>INFORMATION DATE</b> <input type="text"/> / <input type="text"/> / <input type="text"/> Month Day Year	Does the client perceive that their life has value and worth?	Does the client perceive that they have support that they have from others who will listen to their problems?	Does the client perceive they have a tendency to bounce back after hard times?
Strongly disagree	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Somewhat disagree	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neither agree nor disagree	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Somewhat agree	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Client refused	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Client doesn't know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How frequently does the client feel nervous, tense, worried, frustrated, or afraid?

<input type="checkbox"/> Not at all	<input type="checkbox"/> Several times a month	<input type="checkbox"/> At least every day	<input type="checkbox"/> Client refused
<input type="checkbox"/> Once a month	<input type="checkbox"/> Several times a week	<input type="checkbox"/> Client doesn't know	

## EMPLOYMENT

Is the client employed?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
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If **YES**, specify the type of employment.

<input type="checkbox"/> Full-time	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Part-time	<input type="checkbox"/> Client refused
<input type="checkbox"/> Seasonal/sporadic (including day labor)	

If **NO**, specify the reason the client is not employed.

<input type="checkbox"/> Looking for work	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Unable to work	<input type="checkbox"/> Client refused
<input type="checkbox"/> Not looking for work	

## DOMESTIC VIOLENCE

Is the client a domestic violence victim or survivor?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
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If **YES**, when did the experience occur?

<input type="checkbox"/> Within the past three months	<input type="checkbox"/> One year ago or more
<input type="checkbox"/> Three to six months ago (excluding six months exactly)	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Six months to one year ago (excluding one year exactly)	<input type="checkbox"/> Client refused

If **YES**, is the client currently fleeing?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
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## CONTACT INFORMATION

Address \_\_\_\_\_ Apt/Unit \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_ County \_\_\_\_\_

County \_\_\_\_\_

What is the data quality of the client's residence or last permanent address?

<input type="checkbox"/>	Full address reported	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Incomplete or estimated address reported	<input type="checkbox"/>	Client refused

Phone number \_\_\_\_\_ Email address \_\_\_\_\_

START DATE

		/			/			
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Month

Day

Year

END DATE (if applicable)

		/			/			
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Month

Day

Year

Landlord's Name \_\_\_\_\_ Landlord's Address \_\_\_\_\_

Landlord's City \_\_\_\_\_ Landlord's State \_\_\_\_\_ Landlord's Phone \_\_\_\_\_

## EMERGENCY CONTACT

Contact's Name \_\_\_\_\_ Contact's Address \_\_\_\_\_

Contact's City \_\_\_\_\_ Contact's State \_\_\_\_\_ Landlord Phone \_\_\_\_\_

Second Phone Number \_\_\_\_\_ Relationship to Client \_\_\_\_\_

START DATE

		/			/			
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Month

Day

Year

END DATE (if applicable)

		/			/			
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Month

Day

Year

## EMPLOYER CONTACT

Employer Name \_\_\_\_\_ Employer's Address \_\_\_\_\_

Employer's City \_\_\_\_\_ Employer's State \_\_\_\_\_ Employer's ZIP Code \_\_\_\_\_

Employer Phone Number \_\_\_\_\_ Employer Email Address \_\_\_\_\_