HMIS INTAKE –CDPHP INITIATIVE ADULT AND UNACCOMPANIED MINOR

PROJECT		
INTAKE DATE	**BED/UNIT**	**PRIMARY WORKER**
/ /		

FIRST NAME	MIDDLE NAME	LAST NAME (and Suffix)

NAME DATA QUALITY

❑ Full Name Reported ❑ Partial Name, Street Name or Code Name Reported
❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

ALIAS	BIRTHDATE
	/ /

BIRTHDATE DATA QUALITY

❑ Full DOB Reported ❑ Approximate or Partial DOB Reported
❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

SOCIAL SECURITY NUMBER

(enter "9" for any missing numbers in an Approximate or Partial SSN)

___ ___ ___ - ___ ___ - ___ ___ ___ ___

SSN DATA QUALITY

❑ Full SSN Reported ❑ Approximate or Partial SSN Reported
❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

GENDER

❑ Male ❑ Female ❑ Other (explain)
❑ Transgender Female to Male ❑ Transgender Male to Female
❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

ETHNICITY

❑ Hispanic ❑ Non-Hispanic
❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

RACE (choose all that apply)

❑ American Indian/Native Alaskan ❑ Black ❑ White
❑ Asian ❑ Native Hawaiian or Other Pacific Islander
❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

STREET (MAILING) ADDRESS		
CITY	**STATE**	**ZIP**
COUNTY	**PHONE**	**MOVE-IN DATE**

VETERAN STATUS

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

RESIDENCE PRIOR TO PROGRAM ENTRY	
❑ Emergency shelter, including hotel or motel paid for with emergency shelter voucher	❑ Rental by client, no ongoing subsidy
❑ Foster care home or foster care group home	❑ Rental by client with GPD TIP subsidy
❑ Hospital or other residential non-psychiatric medical facility	❑ Rental by client with VASH subsidy
❑ Hotel or Motel paid for without emergency voucher	❑ Rental by client with other ongoing housing subsidy
❑ Jail, prison or juvenile detention facility	❑ Residential project or halfway house with no homeless criteria
❑ Long-term care facility or nursing home	❑ Safe Haven
❑ Owned by client, no ongoing subsidy	❑ Staying or in a family member's room, apartment or house
❑ Owned by client WITH ongoing subsidy	❑ Staying or in a friend's room, apartment or house
❑ Perm. Supportive housing for formerly homeless persons (CoC project, HUD legacy program, HOPWA)	❑ Substance abuse treatment facility or detox center
	❑ Transitional housing for homeless persons (incl. homeless youth)
	❑ Other (describe) _____
❑ Place not meant for human habitation (vehicle, abandoned building, bus/train/subway station etc)	❑ Client doesn't know
	❑ Client refused
❑ Psychiatric hospital or other psychiatric facility	❑ Data not collected

LENGTH OF STAY IN PREVIOUS PLACE		
❑ 1 day or less	❑ 2 days to 1 week	❑ More than 1 week but less than 1 month
❑ 1 to 3 months	❑ More than 3 months, less than 1 year	❑ 1 year or longer
❑ Client Doesn't Know	❑ Client Refused	❑ Data Not Collected

CONTINUALLY HOMELESS FOR AT LEAST 1 YEAR				
❑ No	❑ Yes	❑ Client Doesn't Know	❑ Client Refused	❑ Data Not Collected

NUMBER OF TIMES THE CLIENT HAS BEEN HOMELESS IN THE PAST 3 YEARS						
❑ 1	❑ 2	❑ 3	❑ 4+	❑ Client Doesn't Know	❑ Client Refused	❑ Data Not Collected

TOTAL NUMBER OF MONTHS HOMELESS IN THE PAST 3 YEARS											
❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10	❑ 11	❑ 12
❑ More than 12			❑ Client Doesn't Know			❑ Client Refused			❑ Data Not Collected		

(If more than 12 months) **Number of Years Continuously Homeless: ____**

Total number of months continually homeless immediately prior to project entry: _____

Homeless Status Documented: ❑ No ❑ Yes

HOUSING STATUS		
❑ Category 1 - Homeless	❑ At-risk of homelessness	
❑ Category 2 - At imminent risk of losing housing	❑ Stably housed	
❑ Category 3 - Homeless only under other federal statutes	❑ Client doesn't know	
❑ Category 4 - Fleeing domestic violence	❑ Client refused	❑ Data not collected

INCOME FROM ANY SOURCE (monthly)				
❑ No	❑ Yes	❑ Client Doesn't Know	❑ Client Refused	❑ Data Not Collected

IF YES:			
❑ Earned Income	$_____	❑ Unemployment Insurance	$_____
❑ SSI	$_____	❑ SSDI	$_____
❑ VA Service-Connected Disability Compensation	$_____	❑ VA Non-Service Connected Disability Pension	$_____
❑ Private Disability Insurance	$_____	❑ Worker's Compensation	$_____
❑ TANF	$_____	❑ General Public Assistance	$_____
❑ Retirement from SSA	$_____	❑ Pension or Retirement from former job	$_____
❑ Child Support	$_____	❑ Alimony or Other Spousal Support	$_____
❑ Other	$_____		

NON CASH BENEFITS FROM ANY SOURCE				
❑ No	❑ Yes	❑ Client Doesn't Know	❑ Client Refused	❑ Data Not Collected

IF YES:		
❑ SNAP	❑ Special Supplemental Nutrition Program for Women, Infants and Children	
❑ TANF Child Care Services	❑ TANF Transportation Services	❑ Other TANF Funded Srvcs
❑ Section 8, Public Housing or Other Ongoing Rental Assistance		❑ Temporary Rental Assistance
❑ Other Source		

COVERED BY HEALTH INSURANCE

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

IF YES:

MEDICAID ..... ❑ No ❑ Yes		MEDICARE ..... ❑ No ❑ Yes	
State Children's Health Insurance Program ..... ❑ No ❑ Yes		VA Medical Services ..... ❑ No ❑ Yes	
Employer provided Health insurance ..... ❑ No ❑ Yes		Health ins. via COBRA ..... ❑ No ❑ Yes	
Private Pay Health Insurance ..... ❑ No ❑ Yes		State Health Ins. Adults ..... ❑ No ❑ Yes	

PHYSICAL 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

Documentation of the disability and severity on file: ..... ❑ No ❑ Yes

Currently receiving services or treatment for this condition: ..... ❑ No ❑ Yes

DEVELOPMENTAL 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:

❑ No ❑ Yes ❑ Client Doesn't Know ❑ Client Refused ❑ Data Not Collected

Documentation of the disability and severity on file: ..... ❑ No ❑ Yes

Currently receiving services or treatment for this condition: ..... ❑ No ❑ Yes

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

Documentation of the disability and severity on file: ..... ❑ No ❑ Yes

Currently receiving services or treatment for this condition: ..... ❑ No ❑ Yes

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

Documentation of the disability and severity on file: ..... ❑ No ❑ Yes

Currently receiving services or treatment for this condition: ..... ❑ No ❑ Yes

MENTAL HEALTH

❑ 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

Documentation of the disability and severity on file: ..... ❑ No ❑ Yes

Currently receiving services or treatment for this condition: ..... ❑ No ❑ Yes

SUBSTANCE ABUSE PROBLEM

❑ Alcohol Abuse ❑ Drug Abuse ❑ Both Alcohol and Drug Abuse

❑ No ❑ 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

Documentation of the disability and severity on file: ..... ❑ No ❑ Yes

Currently receiving services or treatment for this condition: ..... ❑ No ❑ Yes

DOMESTIC ABUSE VICTIM/SURVIVOR				
❑ No	❑ Yes	❑ Client Doesn't Know	❑ Client Refused	❑ Data Not Collected

LAST GRADE COMPLETED		
❑ Less than Grade 5	❑ Grades 5-6	❑ Grades 7-8
❑ Grades 9-11	❑ Grade 12	❑ School did not have grade levels
❑ GED	❑ Some College	❑ Client Doesn't Know
❑ Client Refused	❑ Data Not Collected	

ZIP CODE OF LAST PERMANENT ADDRESS	ZIP CODE DATA QUALITY	DATE LEFT LAST PERMANENT ADDRESS
	❑ Full or Partial Zip Code ❑ Don't Know ❑ Refused	

INDIVIDUAL/FAMILY TYPE		
❑ Individual Male	❑ Individual Female	❑ Individual Male Youth (<18)
❑ Individual Female Youth (<18)	❑ Single Parent Family, Male Head	❑ Single Parent Family, Female Head
❑ Single Parent Family, Youth Head (<18)	❑ Two Parent Family, Adult	❑ Two Parent Family, Youth
❑ Adult Couple without Children	❑ N/A	

HOUSEHOLD SIZE	NUMBER OF CHILDREN	AGE/SEX OF CHILDREN		
		AGE / GENDER	AGE / GENDER	AGE / GENDER

AGE/SEX OF CHILDREN					
AGE / GENDER	AGE / GENDER	AGE / GENDER	AGE / GENDER	AGE / GENDER	AGE / GENDER

POST SECONDARY DEGREE		
❑ None	❑ Associates Degree	❑ Bachelors Degree
❑ Masters Degree	❑ Doctorate	❑ Other Graduate/Professional Degree
	❑ Certificate of Advanced Training or Skilled Artisan	
❑ Client Doesn't Know	❑ Client Refused	❑ Data Not Collected

MARITAL STATUS			HA #
❑ Single	❑ Married	❑ Common Law	
❑ Divorced	❑ Separated	❑ Remarried	
❑ Widow(er)			

SERVICES SOUGHT	
❑ Client has CDPHP Managed Medicaid	❑ Client does not have CDPHP Managed Medicaid
❑ Client has completed CDPHP release form	❑ Client needs new medical insurance card
❑ Client requests contact from Nurse Case Manager	❑ CDPHP Member Services contacted 518-641-3466

EMERGENCY CONTACT		
NAME		
ADDRESS		
CITY	STATE	ZIP

RELATION						
❑ Grandparent	❑ Parent	❑ Stepparent	❑ Sibling	❑ Guardian	❑ Uncle	❑ Aunt
❑ Spouse	❑ In-Law	❑ Cousin	❑ Friend	❑ Provider	❑ Child	

PHONE	PHONE	EMAIL
❑ Home ❑ Work ❑ Cell	❑ Home ❑ Work ❑ Cell	

CARES Regional HMIS Consumer Information Consent Form

Information collected in the HMIS database is protected in compliance with the standards set forth in the Health Insurance Portability and Accountability Act (HIPAA) and the U.S. Department of Housing and Urban Development HMIS Data Standards. Every person and agency that is authorized to read or enter information into the database has signed an agreement to maintain the security and confidentiality of the information. Any person or agency that is found to violate their agreement may have their access rights terminated and may be subject to further penalties.

I UNDERSTAND THAT:

- The partner agencies may share limited identifying information about the people they serve with other parties working to end homelessness.
- The release of my information does not guarantee that I will receive assistance. This release of information includes public funded cash disbursements received during the past 3 years.
- This authorization will remain in effect for a minimum of 36 months unless I revoke it in writing, and I may revoke authorization at any time by signing a written statement or Revocation form.
- The following personal information will NOT be shared with any HMIS partner agencies via this HMIS computer system.
    - HIV/AIDS information, such as status, diagnostic test results, mode of transmission, sexuality.
    - Domestic violence information, such as abuse history, abuser information, trauma information.
    - Behavioral health information, such as substance and alcohol abuse and mental illness.
    - Clients supportive services contacts, medication information and case notes.
- If I revoke my authorization, all information about me already in the database will remain, but will become invisible to all of the partner agencies, except public (county, state or federal) cash disbursements.
- If I am applying for county, state or federal cash disbursements such as ESG or SSVF, this information will be shared with Collaborative users and State agencies.

By signing this form, I agree to share the following level of information with other partner agencies via the HMIS computer system:

- ❑ *I agree to share my name (first, middle, last), gender, program enrollment, and exit dates information via the HMIS system with other partner agencies.*
- ❑ *I agree to share my name, gender, ancestry, program enrollment and exit dates, demographic information, miscellaneous section, and contacts information, cash disbursements via the HMIS system with other partner agencies.*
- ❑ *I do not agree to share any of my information via the HMIS system with other HMIS partner agencies via the HMIS computer system. Exception is cash disbursements as noted above.*

Signature: _____ Date: _____