



NHMIS HOPWA Intake/Admission form

***Intake/Admission Date:** ___/___/___ **Primary Worker:** _____

Client Location (Continuum of Care): {Pre-Populated}

Information Sharing Level: (consent form) **Referred By:** _____

***First Name:** _____ **Middle Name:** _____ ***Last Name:** _____

Alias _____ **Suffix** _____

***Name Data Quality:** Full name reported Partial, street name, or code name reported
(Select one) Client doesn't know Client refused Data not collected

***Social Security Number:** ___/___/___ ***SSN Data Quality :** (select one)
 Full SSN Reported
 Approximate or Partial SSN Reported
 Client doesn't know
 Client refused
 Data not collected

***Gender:** (select one) Female Male
 Transgender A gender that is not singularly 'Female 'or 'Male'
 Client refused Questioning Client doesn't know
 Data not collected

***Birth Date:** ___/___/___ ***Birth date Data Quality :** (select one)
 Full DOB Reported
 Approximate or Partial DOB
 Client doesn't know
 Client refused
 Data not collected

***Ethnicity:** (select one) Non-Hispanic/Non-Latin(a)(o)(x) Hispanic/Latin(a)(o)(x)
 Client doesn't know Client refused Data not collected

***Race:** (select all that apply)
 American Indian/Alaska Native / or Indigenous Asian or Asian American
 Black/African American, or African Native Hawaiian/Pacific Islander
 White Client doesn't know
 Client refused Data not collected

***Veteran Status:** (select one)
 No Yes Client doesn't know Client refused Data not collected

Prior Living Situation

***Type of Residence:** (select one)

-Homeless Situation-

- Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train subway station/airport or anywhere outside)
- Emergency Shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home Shelter
- Safe Haven

-Institutional Situations-

- Foster care home 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

-Temporary and Permanent Housing Situation-

- Residential project or halfway house with no homeless criteria
- Hotel or motel paid for without emergency shelter voucher
- Transitional housing for homeless persons (including homeless youth)
- Host Home (non-crisis)
- Staying or living in a friend's room, apartment or house
- Staying or living in a family member's room, apartment or house
- Rental by client, with GPD TIP subsidy
- Rental by client, with VASH subsidy
- Permanent Housing (other than RRH) for formerly homeless persons
- Rental by client, with RRH or equivalent subsidy
- Rental by client, with HCV voucher (tenant or project based)
- Rental by client in a public housing unit
- Rental by client, no ongoing housing subsidy
- Rental by client, with other ongoing housing subsidy
- Owned by client, with ongoing housing subsidy
- Owned by client, no ongoing housing subsidy

-Unknown Options-

- Client doesn't know
- Client refused
- Data not collected

***Length of Stay in Prior Living Situation: (select one)**

- One night or less
- One week or more, but less than one month
- 90 days or more, but less than one year
- Client doesn't know
- Data not collected
- Two to six nights
- One month or more, but less than 90 day's
- One year or longer
- Client refused

***Approximate date homelessness started: ____/____/____**

***(Regardless of where they stayed last night) Number of times the client has been on the streets, in ES, or SH in the past three years including today: (select one)**

- One Time
- Two Times
- Three Times
- Four or more times
- Client doesn't know
- Client Refused
- Data not collected

***Total number of months homeless on the street, in ES or SH in the past three years: (select one)**

- One month (this time is the first month)
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- More than 12 months
- Client doesn't know
- Client Refused
- Data not collected

Chronically Homeless (auto-calculated)

Housing Move-In Date

(Transitional Housing, Permanent Housing Programs, Short term rental, Mortgage, Utility Assistance)

***Has the client been placed into Permanent Housing?**

- No
- Yes

(If Yes) Specify Permanent Housing Move In Date ____/____/____

Resident Unit _____

***Income from any source: No Yes Client doesn't know Client refused Data not collected**

***Monthly Income Sources: (select all that apply)**

- Earned Income \$ _____
- SSI: \$ _____
- VA service-connected disability compensation \$ _____
- Private disability insurance \$ _____
- TANF \$ _____
- Retirement income from SSA \$ _____

- Child Support \$ _____
- Other \$ _____
- Unemployment Insurance \$ _____
- SSDI \$ _____
- VA non-service-connected disability pension \$ _____
- Worker's compensation \$ _____
- General public assistance \$ _____
- Pension or retirement income from a former job \$ _____
- Alimony or other spousal support \$ _____

***Non-Cash Benefits from any source:** (select one)

- No Yes Client doesn't know Client refused Data not collected

***Non-Cash Benefits:** (select all that apply)

- SNAP (Food Stamps) Special Supplemental Nutrition Program for Women, Infants, & Children (WIC)
- TANF Child Care services TANF transportation services
- Other TANF-funded services Other source: _____

***Covered by Health Insurance:** (select one; if answer is yes please complete below)

- No Yes Client doesn't know Client refused Data not collected

MEDICAID: No Yes **MEDICARE:** No Yes

***(If no) Specify Reason:** (select one) ***(If no) Specify Reason:** (select one)

- Applied: decision pending Applied: decision pending
- Applied: client not eligible Applied: client not eligible
- Client did not apply Client did not apply
- Insurance type N/A for this client Insurance type N/A for this client
- Client doesn't know Client doesn't know
- Client refused Client refused
- Data not collected Data not collected

State Children's Health Insurance program: No Yes

***(If no) Specify Reason:** (select one)

- Applied: decision pending
- Applied: client not eligible
- Client did not apply

Insurance type N/A for this client

Client doesn't know

Client refused

Data not collected

Veterans Administrations (VA) Medical Services: No Yes

*(If no) Specify Reason: (select one)

Applied: decision pending

Applied: client not eligible

Client did not apply

Insurance type N/A for this client

Client doesn't know

Client refused

Data not collected

Employer-Provided Health Insurance: No Yes

*(If no) Specify Reason: (select one)

Applied: decision pending

Applied: client not eligible

Client did not apply

Insurance type N/A for this client

Client doesn't know

Client refused

Data not collected

Health Insurance obtained through COBRA: No Yes

*(If no) Specify Reason: (select one)

Applied: decision pending

Applied: client not eligible

Client did not apply

Insurance type N/A for this client

Client doesn't know

Client refused

Data not collected

Private Pay Health Insurance No Yes

*(If no) Specify Reason: (select one)

- Applied: decision pending
- Applied: client not eligible
- Client did not apply
- Insurance type N/A for this client
- Client doesn't know
- Client refused
- Data not collected

State Health Insurance for Adults: No Yes

*(If no) Specify Reason: (select one)

- Applied: decision pending
- Applied: client not eligible
- Client did not apply
- Insurance type N/A for this client
- Client doesn't know
- Client refused
- Data not collected

Indian Health Services: No Yes

*(If no) Specify Reason: (select one)

- Applied: decision pending
- Applied: client not eligible
- Client did not apply
- Insurance type N/A for this client
- Client doesn't know
- Client refused
- Data not collected

Other: No Yes – Please specify: _____

*(If no) Specify Reason: (select one)

- Applied: decision pending
- Applied: client not eligible
- Client did not apply
- Insurance type N/A for this client
- Client doesn't know
- Client refused

Data not collected

Special Needs:

***Physical Disability:** (select one)

No Yes Client doesn't know Client refused Data not collected

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

***Developmental Disability:** (select one)

No Yes Client doesn't know Client refused Data not collected

***Chronic Health Condition:** (select one)

No Yes Client doesn't know Client refused Data not collected

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:** (select one)

No Yes Client doesn't know Client refused Data not collected

***Mental Health Disorder:** (select one)

No Yes Client doesn't know Client refused Data not collected

(If client has a mental health problem) **Expected to of long-continued and indefinite duration and substantially impairs ability to live independently?**

No Yes Client doesn't know Client refused Data not collected

***Substance Use Disorder:** (select one)

No Alcohol Abuse Drug Abuse Both Alcohol & Drug Abuse Client doesn't know
Client refused Data not collected

(If client has a substance abuse problem) **Expected to of long-continued and indefinite duration and substantially impairs ability to live independently?**

No Yes Client doesn't know Client refused Data not collected

Disabling Condition: (auto calculated)

Domestic Violence

***Information Date:** _____

***Domestic Violence Victim/Survivor:** (select one)

No Yes Client doesn't know Client refused Data not collected

***(If Yes) When experience occurred:** (select one)

- Within the past three months
- Three to six months ago
- From six to twelve months ago
- More than a year ago
- Client doesn't know
- Client refused
- Data not collected

***Are you currently fleeing?** (select one)

- No
- Yes
- Client doesn't know
- Client refused
- Data not collected

HIV/AIDS Medical Assistance:

***Receiving Public HIV/AIDS Medical Assistance:** (select one)

- No
- Yes
- Client doesn't know
- Client refused
- Data not collected

***(If No) Reason:** (select one)

- Applied: decision pending
- Applied: client not eligible
- Client did not apply
- Insurance type N/A for this client
- Client doesn't know
- Client refused
- Data not collected

***Receiving AIDS Drug Assistance Program (ADAP):** (select one)

- No
- Yes
- Client doesn't know
- Client refused
- Data not collected

***(If No) Reason:** (select one)

- Applied: decision pending
- Applied: client not eligible
- Client did not apply
- Insurance type N/A for this client
- Client doesn't know
- Client refused
- Data not collected

***Receiving Ryan White-funded Medical or Dental Assistance:**

- No
- Yes
- Client doesn't know
- Client refused
- Data not collected

***(If No) Reason:** (select one)

- Applied: decision pending
- Applied: client not eligible
- Client did not apply
- Insurance type N/A for this client
- Client doesn't know
- Client refused
- Data not collected

T-Cell (CD4) and Viral Load

***Information Date:** ___/___/___

***T-Cell (CD4) Count Available:** (select one)

- No
- Yes
- Client doesn't know
- Client refused
- Data not collected

***(If Yes) T-Cell Count:** _____

***(If Yes) How was the information obtained:** (select one)

- Medical Report
- Client Report
- Other

***Viral Load Information Available:** (select one)

- Not Available
- Available
- Undetectable
- Client doesn't know
- Client refused
- Data not collected

***(If Yes) Viral Load:** _____

***(If Yes) How was the information obtained:** (select one)

- Medical Report
- Client Report
- Other

***Has the participant been prescribed anti-retroviral drugs:**

- No
- Yes
- Client doesn't know
- Client refused
- Data not collected

Household Composition:

***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
- Two Parent Family – Adult
- Two Parent Family – Youth
- Adult Couple w/o Children
- Household w/only Children
- Other household type
- Household member - adult
- Household member – child

Household Size _____

Non-HMIS Data Elements:(Hotel/Motel Vouchers programs)

***Homeless Cause:** (select one)

- Benefits Loss/Reduction
- Job Income Loss/Reduction
- Eviction
- Relocation
- Release from prison/jail
- Release from Hospital
- Release from Psych. Facility
- Illness
- Unknown
- Rent Increase/Insufficient Income
- Household Breakup/Death in Household
- Injury
- Domestic Violence
- Asked to leave shared residence
- Drug/Alcohol Abuse
- Other
- Natural Disaster
- Foreclosure – Rented Property
- Foreclosure – Owned Property
- Not Homeless
- Mental Illness
- Substandard Housing

***Zip Code of Last Permanent Address:** _____ (enter five 9's if they don't know zip code)

Zip Code Data Quality: (select one)

Full/Partial Zip Code Reported Don't know Refused

***Current Student:** (select one)

Yes No Don't know Refused

***Received vocational training or apprenticeship certificate:** (select one)

Yes No Don't know Refused

Children's Education Questions:

***Education Enrollment Status:** (select one) Yes No Don't know Refused

If yes, was/is the child connected to the McKinney-Vento Homeless Assistance Act school liaison?

(Select one) Yes No Don't know Refused

Type of School: (select one)

Public school Parochial or other private school Don't know Refused

If not enrolled, last date of enrollment [MM/YYYY]: ____/____

***Student Body Age:** (select one)

<input type="checkbox"/> Nursery/Preschool	<input type="checkbox"/> Six-Year High School
<input type="checkbox"/> Kindergarten School	<input type="checkbox"/> High School – Other than listed above
<input type="checkbox"/> Elementary School	<input type="checkbox"/> Special Elem/Sec. School for Handicapped
<input type="checkbox"/> Middle School	<input type="checkbox"/> Special Elementary School for Handicapped
<input type="checkbox"/> Approved Junior High School	<input type="checkbox"/> Special Secondary School for Handicapped
<input type="checkbox"/> Four-Year High School	<input type="checkbox"/> Three-Year School
<input type="checkbox"/> County Voc-Tech School or Institute	<input type="checkbox"/> Adult Education School
<input type="checkbox"/> Evening High School (Approved)	<input type="checkbox"/> Evening School for Foreign Born (Approved)

***School County:** _____

***School District:** _____

***School Name:** _____

***Barriers to Enrollment:** (select all that apply)

<input type="checkbox"/> None	<input type="checkbox"/> School Records
<input type="checkbox"/> School Selection	<input type="checkbox"/> Transportation
<input type="checkbox"/> Immunization or Other Medical Records	<input type="checkbox"/> Other Enrollment Issues
<input type="checkbox"/> Residency Required	<input type="checkbox"/> Birth Certificates
<input type="checkbox"/> Legal Guardianship requirements	<input type="checkbox"/> Physical examination records

***Marital Status:** (select one)

- Single Married Common Law Divorced Separated Remarried
Widow(er) Civil Union

HA# _____

***Services Sought:** (select all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Shelter/Housing | <input type="checkbox"/> Drug Treatment |
| <input type="checkbox"/> Mental Health Care | <input type="checkbox"/> Medical Care |
| <input type="checkbox"/> Legal Aid – CRSJ/Civil | <input type="checkbox"/> Legal Aid – Immigration |
| <input type="checkbox"/> Financial Assistance – Utilities | <input type="checkbox"/> Financial Assistance – Housing |
| <input type="checkbox"/> Financial Assistance – Moving Expense | <input type="checkbox"/> Financial Assistance – Other |
| <input type="checkbox"/> Other | |