2023 Adult CoC HMIS Intake Form

Date of Intake _____

CLIENT'S NAME		N/A
Last		
First		☐
Middle		☐
Suffix		☐

QUALITY OF NAME

☐ Full name reported	☐ Partial, street name, or code name reported	☐ Client doesn't know	☐ Client Prefers Not to Answer	☐ Data not collected

DATE OF BIRTH	Month ___ Day ___ Year ___	Age:

QUALITY OF DOB

☐ Full DOB reported	☐ Approximate or partial DOB reported	☐ Client doesn't know	☐ Client Prefers Not to Answer	☐ Data not collected

SOCIAL SECURITY NUMBER (SSN)	

QUALITY OF SSN

☐ Full SSN reported	☐ Approximate or partial SSN reported	☐ Client doesn't know	☐ Client Prefers Not to Answer	☐ Data not collected

GENDER

☐ Man (Boy, if child) ☐ Woman (Girl, if child) ☐ Culturally specific Identity (e.g., Two-Spirit) ☐ Different Identity	☐ Non-Binary ☐ Transgender ☐ Questioning	☐ Client doesn't know ☐ Client Prefers Not to Answer ☐ Data not collected

RACE AND ETHNICITY

☐ American Indian, Alaska Native, or Indigenous ☐ Asian or Asian American ☐ Black, African American, or African	☐ Hispanic/Latina/e/o ☐ Middle Eastern or North African ☐ Native Hawaiian or Pacific Islander ☐ White	☐ Client doesn't know ☐ Client Prefers Not to Answer ☐ Data not collected

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VETERAN STATUS

☐ Yes	☐ Client doesn't know
☐ No	☐ Client Prefers Not to Answer
	☐ Data not collected

RELATIONSHIP TO HEAD OF HOUSEHOLD

☐ Self (head of household) ☐ Head of household's child ☐ Head of household's spouse or partner	☐ Head of household's other relation member ☐ Other: non-relation member

PROJECT NAME	
PROJECT START DATE	____ — ____ — ____
HOUSING MOVE-IN DATE *(For PSH, PH with no disability requirement, and RRH Projects: Record the date a client or household moves into a permanent housing unit)*	____ — ____ — ____

	Homeless	Institutional	Transitional and Permanent	
Section 1	☐ Place not meant for habitation (e.g.,a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) ☐ Safe Haven	☐ 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	☐ Hotel or motel paid for without emergency shelter voucher ☐ Owned by client, no ongoing housing subsidy ☐ Owned by client, with ongoing housing subsidy ☐ Rental by client, no ongoing housing subsidy ☐ Staying or living in a family member's room, apartment, or house ☐ Staying or living in a friend's room, apartment, or house ☐ Transitional housing for homeless persons (including homeless youth) ☐ Rental by client, with ongoing housing subsidy (Subsidy Type _____)	☐Client Doesn't Know ☐Client Prefers Not to Answer ☐Other ☐Data Not Collected

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			☐ Residential project or halfway house with no homeless criteria ☐ Post Home (non-crisis)	
Section 2	Length of Stay for Section 1: ☐ One night or less ☐ Two to six nights ☐ One week or more but less than one month ☐ One month or more but less than 90 days ☐ 90 days to less than one year ☐ One year or longer	Length of Stay for Section 1: ☐ One night or less ☐ Two to six nights ☐ One week or more but less than one month ☐ One month or more but less than 90 days ☐ 90 days to less than one year ☐ One year or longer	Length of Stay for Section 1: ☐ One night or less ☐ Two to six nights ☐ One week or more but less than one month ☐ One month or more but less than 90 days ☐ 90 days to less than one year ☐ One year or longer	☐Client Doesn't Know ☐Client Prefers Not to Answer ☐Data Not Collected
Section 3	Skip to Section 4	Was stay less than 90 days? ☐ No--END ☐ Yes If yes, on the night before did you stay on the streets, in a ES or SH? ☐ Yes ☐ No	Was stay 7 nights or less? ☐ No--END ☐ Yes If yes, on the night before did you stay on the streets, in a ES or SH? ☐ Yes ☐ No	☐Client Doesn't Know ☐Client Prefers Not to Answer ☐Data Not Collected
Section 4	Start date of current homeless episode _____/_____/_____ Number of times of homelessness in the past 3 years: ☐ Never in 3 years ☐1 ☐2 ☐3 ☐4 or more Total number of homeless months in the past 3 yrs: If 0-12 months, specify #_____ ☐ More than 12 months			☐Client Doesn't Know ☐Client Prefers Not to Answer ☐Data Not Collected

Are you a survivor of domestic or intimate partner violence?

☐ No ☐ Yes	If yes, currently fleeing? ☐ No ☐ Yes If yes, how long?_____	☐ Client doesn't know ☐ Client Prefers Not to Answer ☐ Data not collected
If yes for survivor of domestic or intimate partner violence		
When did this experience occur?	☐ Within the past three months ☐ Three to six months ago (excluding six months exactly) ☐ From six to twelve months ago (excluding one year exactly) ☐ More than a year ago	☐ Client doesn't know ☐ Client Prefers Not to Answer ☐ Data not collected

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Are you currently fleeing?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client Prefers Not to Answer ☐ Data not collected

Receiving Non-Cash Benefits?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client Prefers Not to Answer ☐ Data not collected
IF "YES" TO RECEIVING NON-CASH BENEFITS– INDICATE ALL SOURCES THAT APPLY		
☐ Supplemental Nutrition Assistance Program (SNAP)	☐ TANF Transportation Services	
☐ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	☐ Other TANF-funded services	
☐ TANF Childcare Services	☐ Other Non-Cash Benefits (Specify Source):_____	

Covered by Health Insurance?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client Prefers Not to Answer ☐ Data not collected

General Health Status	☐ Excellent	☐ Fair	☐ Client Prefers Not to Answer
	☐ Very Good	☐ Poor	☐ Data not collected
	☐ Good	☐ Client doesn't know	

(PH programs only)

Sexual Orientation	☐ Heterosexual	☐ Bisexual	☐ Client Prefers Not to Answer
	☐ Gay	☐ Questioning / Unsure	☐ Data not collected
	☐ Lesbian	☐ Other_____	☐ Client doesn't know

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Checkmark the correct response:

Well Being	Strong disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Client doesn't know	Client Prefers Not to Answer	Data not collected
Client perceives their life has value and worth.								
Client perceives they have support from others who will listen to problems.								
Client perceives they have a tendency to bounce back after hard times.								

Client's frequency of feeling nervous, tense, worried, frustrated, or afraid.	
Not at all	
Once a month	
Several times a month	
Several times a week	
At least every day	
Client doesn't know	
Client Prefers Not to Answer	
Data not collected	

Substance Use Disorder	
No	
Alcohol Use Disorder	
Drug Use Disorder	
Both Alcohol and Drug Use Disorders	
Client doesn't know	
Client Prefers Not to Answer	
Data not collected	

Mental Health Disorder	
No	
Yes	
Client doesn't know	
Client Prefers Not to Answer	
Data not collected	

Developmental Disability	
No	
Yes	
Client doesn't know	
Client Prefers Not to Answer	
Data not collected	

Chronic Health Condition	
No	
Yes	
Client doesn't know	
Client Prefers Not to Answer	
Data not collected	

HIV/AIDS	
No	
Yes	
Client doesn't know	
Client Prefers Not to Answer	
Data not collected	

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Physical Disability	
No	
Yes	
Client doesn't know	
Client Prefers Not to Answer	
Data not collected	

Translation Assistance	
No	
Yes	
Client doesn't know	
Client Prefers Not to Answer	
Data not collected	

Income from Any Source	☐ No ☐ Yes ☐ Client doesn't know ☐ Client Prefers Not to Answer ☐ Data not collected

IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY	
Income Source (Check all that apply)	**Monthly Amount**
☐ Earned Income	
☐ Unemployment Insurance	
☐ Worker's Compensation	
☐ Private Disability Insurance	
☐ VA Service-Connected Disability Compensation	
☐ Social Security Disability Income (SSDI)	
☐ Supplemental Security Income (SSI)	
☐ Retirement Income from Social Security	
☐ VA Non-Service-Connected Disability Pension	
☐ Pension or retirement income from a former job	
☐ Temporary Assistance for Needy Families (TANF)	
☐ General Assistance (GA)	
☐ Alimony or other spousal support	
☐ Child Support	
☐ Other Cash Income (Specify:_____)	

Covered by Health Insurance?	☐ Yes ☐ No ☐ Client doesn't know ☐ Client Prefers Not to Answer ☐ Data not collected
IF "YES" TO COVERED BY HEALTH INSURANCE– INDICATE ALL SOURCES THAT APPLY	
☐ MEDICAID	☐ Insurance Obtained through COBRA
☐ MEDICARE	☐ Private Pay Health Insurance
☐ State Children's Health Insurance Program	☐ State Health Insurance for Adults
☐ Veteran's Administration (VA) Medical Services	☐ Indian Health Services Program
☐ Employer-provided Health Insurance	☐ Other Health Insurance (Specify Source):_____

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Client Verification

I understand that this document is an application for assistance and that the agency, participating in the West TN Continuum of Care, must review this application before deciding whether to assist me with the program. The agency agrees to notify me as soon as possible of its decision**. I certify that the information provided by me on this application, as well as information provided by me regarding the income and assets of members of my family unit, is true to the best of my knowledge**. I hereby promise to report any changes in this information that may occur while my case is open.

Client's Name _____

Client's Signature _____

Date_____/_____/_____

When applicable:

I, _____ have a received a copy of the following:

_____1. Grievance and Termination Policy

_____2. Fair Housing Information Packet

_____3. Lead Base Paint Information Packet

_____4. Copy of Statement and Understanding

Client's Signature _____Date_____/_____/_____

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West TN Homeless Management Information System (HMIS)

Client Consent Form

IMPORTANT: Do not enter personally identifying information into HMIS for clients who are: 1) in DV agencies or; 2) currently fleeing or in danger from a domestic violence, dating violence, sexual assault or stalking situation. If this applies to you, *STOP-Do Not Sign This Form*

This agency participates in the West TN Homeless Management Information System (HMIS) by collecting information, over time, about the characteristics and service needs of men, women, and children experiencing homelessness or at-risk of homelessness. To provide the most effective services in moving people from homelessness to permanent housing we need to collect some identifying personal information including but not limited to: name, birth date, social security, race, gender and current housing situation.

We will guard this information with strict security policies to protect your privacy. If you ever suspect your data in HMIS has been misused, immediately contact the West TN HMIS Administrator at (731) 651-1020.

_____I understand the sharing policy of HMIS and AUTHORIZE the sharing of the additional personal information in HMIS about me and my dependents listed below to be shared with the agencies and licensed users belonging to the West TN HMIS. Federal and/or State law specifically require that any disclosure of substance use, alcohol or drug, mental health, or AIDS related information must be accompanied by the following statement:

This information has been disclosed to you from records protected by the federal confidentiality rules (42 CFR Part 2): The Federal rules prohibit you from making any further disclosure of information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug use patient.

West TN HMIS Participating Agencies: Aspell Recovery Services, Area Relief Ministries, Community Action Network, Carey Counseling Center, Damascus, Dream Center, Fayette Cares, Jackson Housing Authority, JACOA, Jesus Cares, Pathways Behavioral Health Services, Professional Care Services, Quinco Mental Health Centers, SW Human Resource Agency, Tennessee Homeless Solutions and WRAP.

This Authorization will remain in effect unless revoked in writing to this agency. Revocation of this authorization may take up to three (3) business days to process.

(Adult Name)_____

(Dependent Names)_____

_____

Adult or Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

FOLLOW UP:

PROGRAM ENROLLED IN:_____Date:_____

CASEWORKER:_____

RRH and CoC PSH Programs- MOVE IN DATE ____/_____/_____

PATH ONLY- Date Of Status Determination ____/____/_____