HMIS Data Collection Form for CARR Team.

TRIAGE PERFORMED BY:

TRIAGE DATE:

Month / Day / Year

CLIENT NAME:

Client ID#	
First name	
Middle name	
Last name	
Suffix	
Phone Number	

SOCIAL SECURITY NUMBER: - -

DATE OF BIRTH:

Month / Day / Year

ETHNICITY:

☐ Non-Hispanic / Non-Latino	☐ Client doesn't know
☐ Hispanic / Latino	☐ Client refused

RACE:

☐ American Indian or Alaska Native	☐ White
☐ Asian	☐ Client doesn't know
☐ Black or African American	☐ Client refused
☐ Native Hawaiian or Other Pacific Islander	

GENDER

☐ Female	☐ Gender Non-Conforming (i.e. not exclusively male or female)
☐ Male	
☐ Trans Female (MTF, or male to female)	☐ Client doesn't know
☐ Trans Male (FTM, or female to male)	☐ Client refused

VETERAN STATUS

☐ No	☐ Client doesn't know
☐ Yes	☐ Client refused

If under 18, refer to Huckleberry House @ 614-294-5553

DOMESTIC VIOLENCE

Are you experiencing any violence against you physically or sexually where you live or are staying right now that is making that place unsafe for you to remain?

☐ Yes	☐ No

If Yes, provide client with the phone number to CHOICE @ 614-224-4663

Is client a domestic violence victim/survivor?

☐ No	☐ Client doesn't know
☐ Yes	☐ Client refused

↓

[IF YES] When did the experience occur?

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

↓

[IF WITHIN LAST 30 DAYS] I'd like to refer you to choices domestic violence shelter where they may have additional resources to help with your housing crisis and address additional concerns with your situation. Is that okay?

☐ Yes	☐ No

↓

Refer to CHOICES @ 614-224-4663

↓

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[IF NO] Is there other safe housing where you can stay when you leave?

☐ Yes	☐ No

How many nights can you stay there? (If fewer than 10 days, refer to CHOICES) ☐

Are you presently feeling pressured/threatened to do things (such as sex or labor) you don't want to do?

☐ Yes	☐ No

Are you presently exchanging sex or labor for something of value? (such as food, shelter, drugs, clothing, money)?

☐ Yes	☐ No

↓

If yes to either of the above two questions, offer to provide the number for the local hotline. Warm transfer if possible. National Human Trafficking Hotline (1-888-373-7888)

HOUSEHOLD INFORMATION

Household Composition:

☐ Single Adult Household: One adult, no minor(s)
☐ Family Household: Two or members, at least one minor
☐ Unaccompanied Youth: One minor, no adults

Relationship to Head of Household:

☐ Self (Head of household)	☐ Head of household's other relation member (other relation to head of household)
☐ Head of household's child	
☐ Head of household's spouse or partner	☐ Other: non-relation member
☐ Trans Male (FTM, or female to male)	☐ Data not collected

Number of Adults in Household (incl. HoH):

Besides the HoH, are there any other adults in the household who are Veterans?:

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

Do you have any minor children?: ☐ Yes ☐ No

Do you have legal custody of the minor children currently staying with you?: ☐ Yes ☐ No

Number of Children in Household:

0-2 years ____ 3-7 years ____ 8-12 years ____ 13-17 years ____

Pregnant?:

☐ No	☐ Client doesn't know
☐ Yes	☐ Client refused

Projected Due Date:

		/			/				

Month Day Year

Are you receiving prenatal care?:

☐ No	☐ Yes

If no, provide client with the phone number to STEP ONE (614-721-0009)

LAST PERMANENT ADDRESS

Zip Code of Last Permanent Address?:

General Area Location of Previous Residence:

☐ Within Franklin County (Outside City - Columbus)	☐ Outside Franklin County (Within City - Columbus)
☐ Within Franklin County (Within City - Columbus)	☐ Outside of Ohio
☐ Outside Franklin County (Outside City - Columbus)	☐ Client refused

I now have some additional questions to help me better identify resources that might be useful.

Are you presently on the streets or in a camp or without a safe place to stay tonight

☐ Yes	☐ No

Where did you stay last night? (Prior Living Situation)

Homeless Situations	☐ Place not meant for habitation	**Transitional and Permanent Housing Situations**	☐ Hotel or motel paid for without emergency shelter voucher
	☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher		☐ Owned by client, no ongoing housing subsidy
	☐ Safe Haven		☐ Owned by client, with ongoing housing subsidy
	☐ Interim Housing*		☐ Permanent housing (other than RRH) for formerly homeless persons
Institutional Situations	Foster care home or foster care group home		☐ Rental by client, with no housing subsidy
	☐ Hospital or other residential non-psychiatric medical facility		☐ Rental by client, with GPD TIP housing subsidy
	☐ Jail, prison, or juvenile detention facility		☐ Rental by client, with VASH housing subsidy
	☐ Long-term care facility or nursing home		☐ Rental by client, with other housing subsidy (includin RRH)
	☐ Psychiatric hospital or other psychiatric facility		☐ Residential project or halfway house with no homeless criteria
	☐ Substance abuse treatment facility or detox center		☐ Staying or living in a family member's room, apartment, or house
Other	☐ Client doesn't know		☐ Staying or living in a friend's room, apartment, or house
	☐ Client refused		☐ Transitional housing for homeless persons (including homeless youth)

How long have you been staying there? (Length of Stay in Previous Place)

☐ One night or less	☐ 90 days or more, but less than one year
☐ Two to six nights	☐ One year or longer
☐ One week or more, but less than one month	☐ Client doesn't know
☐ One month or more, but less than 90 days	☐ Client refused

If you are staying with friends/family, can you stay there again tonight? ☐ Yes ☐ No

[If Not] Why do you have to leave this place?

Is there any other friends/family in the area you can stay with? ☐ Yes ☐ No

Where else might you be able to stay?:

How many more night are you able to stay at this location?

Last Grade Completed:

EMPLOYED?:

- ☐ Client refused
- ☐ Yes **# of Hours/week:**_____
  - ☐ Full-time
  - ☐ Part-time
  - ☐ Seasonal/Sporadic
- ☐ Client doesn't know
- ☐ No
  - ☐ Looking for work
  - ☐ Unable to work
  - ☐ Not looking for work

INCOME AND SOURCES:

Does the client have any income from any source?

- ☐ No
- ☐ Yes
- ☐ Client doesn't know
- ☐ Client refused

[IF YES] Answer Yes or No for each income source

Receiving Income?		Source of Income	Monthly amount from source (round to nearest dollar)
☐No	☐Yes	Earned income (employment income)	$. 0 0
☐No	☐Yes	Unemployment Insurance	$. 0 0
☐No	☐Yes	Supplemental Security Income (SSI)	$. 0 0
☐No	☐Yes	Social Security Disability Insurance (SSDI)	$. 0 0
☐No	☐Yes	VA Service-Connected Disability Compensation	$. 0 0
☐No	☐Yes	VA Non-Service-Connected Disability Pension	$. 0 0
☐No	☐Yes	Private disability insurance	$. 0 0
☐No	☐Yes	Worker's Compensation	$. 0 0
☐No	☐Yes	Temporary Assistance for Needy Families (TANF)	$. 0 0
☐No	☐Yes	General Assistance (GA)	$. 0 0
☐No	☐Yes	Retirement Income from Social Security	$. 0 0
☐No	☐Yes	Pension or retirement income from a former job	$. 0 0
☐No	☐Yes	Child support	$. 0 0
☐No	☐Yes	Alimony or other spousal support	$. 0 0
☐No	☐Yes	Other source:_____	$. 0 0
		Total monthly income from all sources	$. **0** **0**

NON-CASH BENEFITS :

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

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused

[IF YES] Answer 'Yes' or 'No' for each non-cash benefit source.

	Receiving Benefits?	
Supplemental Nutrition Assistance Program (SNAP)	☐No	☐Yes
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	☐No	☐Yes
TANF Child Care services *(or use local name)*	☐No	☐Yes
TANF transportation services *(or use local name)*	☐No	☐Yes
Other TANF-Funded Services *(or use local name)*	☐No	☐Yes
Other source, specify source:_____	☐No	☐Yes

HEALTH INSURANCE:

Is the client covered by Health Insurance?

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused

[IF YES] Answer 'Yes' or 'No' for each health insurance source.

No	Yes	Source
☐	☐	Medicaid
☐	☐	Medicare
☐	☐	State Children's Health Insurance Program (or use local name)
☐	☐	Veteran's Administration (VA) Medical Services
☐	☐	Employer-Provided Health Insurance
☐	☐	Health insurance obtained through COBRA
☐	☐	Private Pay Health Insurance
☐	☐	State Health Insurance for Adults (or use local name)
☐	☐	Indian Health Services Program
☐	☐	Other If Yes, specify source: _____

Who do you usually call when you need help?:

Can we contact him/her? ☐ Yes; **Phone Number**:_____ ☐ No

HOMELESS INFORMATION

Homelessness Primary Reason:

☐	Addiction	☐	Jail/Prison
☐	Divorce	☐	Relationship Problems
☐	Domestic Violence	☐	Substandard Housing
☐	Evicted	☐	Unable to Pay Rent/Mortgage
☐	Family/Personal Illness	☐	Unemployment
☐	Fire	☐	Other:_____

Homelessness Secondary Reason:

☐	Addiction	☐	Jail/Prison
☐	Divorce	☐	Relationship Problems
☐	Domestic Violence	☐	Substandard Housing
☐	Evicted	☐	Unable to Pay Rent/Mortgage
☐	Family/Personal Illness	☐	Unemployment
☐	Fire	☐	Other:_____
☐	No Secondary Reason for Crisis		

Date the client started being homeless this time:

		/			/				
Month			Day			Year			

Number of time the client has been homeless in the past three years:

☐	One time (this time)	☐	Four or more times
☐	Two times	☐	Client doesn't know
☐	Three times	☐	Client refused

Total number of months the client has been homeless in the past three years:

☐	One month or less (choose if this is the first time the client has been homeless)	
☐	Between 2 and 12 months ➔	Enter the total number of months:_____
☐	More than 12 months	
☐	Client doesn't know	
☐	Client refused	

Now I have some questions I need to ask about your ability to remain safe while in shelter tonight.

DISABLING CONDITION:

Does the client have a disabling condition that is long-term and impairs their ability to live independently?

☐ No	☐ Client doesn't know
☐ Yes	☐ Client refused

[IF YES] Answer 'Yes' or 'No' for each Disability Type

No	Yes	Disability Type	[IF YES], expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?
☐	☐	Physical Disability	☐No ☐Yes ☐Doesn't Know ☐Refused
☐	☐	Developmental Disability	☐No ☐Yes ☐Doesn't Know ☐Refused
☐	☐	Chronic Health Condition	☐No ☐Yes ☐Doesn't Know ☐Refused
☐	☐	HIV/AIDS	☐No ☐Yes ☐Doesn't Know ☐Refused
☐	☐	Mental Health Problem	☐No ☐Yes ☐Doesn't Know ☐Refused
☐	☐	Substance Abuse: ☐Drug ☐Alcohol ☐Both Drug & Alcohol	☐No ☐Yes ☐Doesn't Know ☐Refused
☐	☐	Other If Yes, specify source: _____	☐No ☐Yes ☐Doesn't Know ☐Refused

Do you have a mental health case manager? ☐ Yes ☐ No

[IF YES] Is she/he aware of the situation?? ☐ Yes ☐ No

Are you presently thinking about hurting yourself or someone else? ☐ Yes ☐ No

[IF YES] I would like you to be seen at Netcare. I can transfer you or call for you (614-276-2273) or you may present there yourself? Their location is: 199 S. Central Ave.

Are you connected with Maryhaven Outreach? ☐ Yes ☐ No

Are you currently linked with Franklin County Children Services?

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

(Clients 18-20 years old) Did you age out of foster care?

☐ Yes	☐ No

If client is in need of shelter, refer to Netcare (614-274-7000).

Notes: