HMIS Data Collection Form for Project START – Emergency Shelters & Outreach

This form can be used by project types: Street Outreach, Emergency Shelters and Safe Havens.

PROJECT START DATE:

		/			/				

Month Day Year

NAME:

Client ID#	
First name	
Middle name	
Last name	
Suffix	

SOCIAL SECURITY NUMBER:

			-			-				

DATE OF BIRTH:

		/			/				

Month Day Year

ETHNICITY:

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

RACE:

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

GENDER

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

VETERAN STATUS

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

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 relation to head of household)
- ☐ Other: non-relation member

RESIDENCE PRIOR TO PROJECT ENTRY

Homeless Situations

- ☐ Place not meant for habitation
- ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher
- ☐ Safe Haven
- ☐ Interim Housing*

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

Other

- ☐ Client doesn't know
- ☐ Client refused

Transitional and Permanent Housing Situations

- ☐ Hotel or motel paid for without emergency shelter voucher
- ☐ Owned by client, no ongoing housing subsidy
- ☐ Owned by client, with ongoing housing subsidy
- ☐ Permanent housing (other than RRH) for formerly homeless persons
- ☐ Rental by client, with no housing subsidy
- ☐ Rental by client, with GPD TIP housing subsidy
- ☐ Rental by client, with VASH housing subsidy
- ☐ Rental by client, with other housing subsidy (including RRH)
- ☐ Residential project or halfway house with no homeless criteria
- ☐ 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)

LENGTH OF STAY IN PRIOR LIVING SITUATION

- ☐ 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 or more, but less than one year
- ☐ One year or longer
- ☐ Client doesn't know
- ☐ Client refused

DATE THE CLIENT STARTED BEING HOMELESS THIS TIME:

		/			/				
Month			Day			Year			

NUMBER OF TIMES THE CLIENT HAS BEEN HOMLESS IN THE PAST THREE YEARS:

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

TOTAL NUMBER OF MONTHS THE CLIENT HAS BEEN HOMLESS 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

HOMELESSNESS PRIMARY REASON:

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

HOMELESSNESS SECONDARY REASON:

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

ZIP CODE OF LAST PERMANENT ADDRESS:

- ☐ Enter Zip:_____
- ☐ Outside of Ohio
- ☐ Client doesn't know
- ☐ Client refused

GENERAL AREA LOCATION OF LAST PERMANENT ADDRESS:

- ☐ Within Franklin County/ Outside City of Columbus
- ☐ Outside Franklin County/ within City of Columbus
- ☐ Outside of Ohio
- ☐ Within Franklin County/ within City of Columbus
- ☐ Outside Franklin County/ Outside City of Columbus
- ☐ Client Refused/ Doesn't Know

MENTAL HEALTH LINKAGE:

If linked with a mental health agency, which one?:

- ☐ Not currently linked but NEEDS linkage
- ☐ Not currently linked, does NOT need linkage

----------Begin HIPAA Assessment----------

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	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

PREGNANT?:

☐ No ☐ Client doesn't know

☐ Yes ☐ Client refused

Projected Due Date:

		/			/				

Month Day Year

Birth Weight:

DOMESTIC VIOLENCE:

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 YES] Is the client currently fleeing?

☐ No ☐ Client doesn't know

☐ Yes ☐ Client refused

----------*End HIPAA Assessment*----------

EMPLOYED?:

- ☐ Client refused
- ☐ Client doesn't know
- ☐ Yes **# of Hours/week:**_____
- ☐ No

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- ☐ Full-time
- ☐ Part-time
- ☐ Seasonal/Sporadic

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- ☐ Looking for work
- ☐ Unable to work
- ☐ Not looking for work

INCOME AND SOURCES:

Does the client have any income from any source?

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

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[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

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[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

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[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: _____

ADULT EDUCATION INFORMATION:

Highest Level of Education Attained:										
Degree Earned (e.g. Bachelor's Degree, Associate's Degree, GED, etc.):										
Degree Status (Complete: Cert. Received/Not Received, In Progress, Incomplete):										
Start Date:			/			/				
End Date:			/			/				

RECEIVED VOCATIONAL TRAINING?:

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

MILITARY INFORMATION:

Military Branch										
Start Date:			/			/				
End Date:			/			/				
Discharge Status			/			/				

Operation	Has the client participated in the following military operations?
World War II	☐No ☐Yes ☐Doesn't Know ☐Refused
Korean War	☐No ☐Yes ☐Doesn't Know ☐Refused
Vietnam War	☐No ☐Yes ☐Doesn't Know ☐Refused
Persian Gulf War	☐No ☐Yes ☐Doesn't Know ☐Refused
Afghanistan	☐No ☐Yes ☐Doesn't Know ☐Refused
Iraqi Freedom	☐No ☐Yes ☐Doesn't Know ☐Refused
Iraqi Dawn	☐No ☐Yes ☐Doesn't Know ☐Refused
Other Peace-keeping Operations or Military Interventions: _____	☐No ☐Yes ☐Doesn't Know ☐Refused

Client Signature:_____ **Date:**_____

Staff Signature:_____ **Date:**_____