

# HMIS Data Collection Form for Project START – PSH, RRH, TH & Prevention

This form can be used by all project types: Prevention, Transitional Housing, Rapid Re-housing, Permanent Supportive Housing, and Services Only.

## FOR TEXT FIELDS, USE BLOCK LETTERS. OTHERWISE, MARK APPROPRIATE BOXES WITH AN “X”

The form is broken into two sections for *All Clients*, and *Head of Household and Other Adults in the Household* in order to eliminate duplication of data gathering when characteristics apply to certain members of households.

### DATA FOR ALL CLIENTS

Respond to the following questions for all household members—each adult and child. A separate form should be included for each household member.

#### PROJECT START DATE (e.g., 08/24/2017)

The Project Start Date will serve as the information date for all data elements collected on this form; all data must be accurate as of this date, regardless of the date collected.

		/			/				
Month			Day					Year	

#### NAME (first, middle, last name, suffix, e.g., Jr, Sr, III)

Use a client's full, legal name whenever possible. Generally, projects do not need to verify that the information provided matches legal documents, unless specifically required by a funder.

Client ID#	
First name	
Middle name	
Last name	
Suffix	

#### NAME DATA QUALITY

Street outreach projects may record a project start with limited information about the client and improve on the accuracy and completeness of client data over time. If using a “made up name” for such an initial identification, indicate that here.

Full name reported

Partial, street name, or code name reported

Client doesn't know

Client refused

#### SOCIAL SECURITY NUMBER

			-			-			
--	--	--	---	--	--	---	--	--	--

#### SOCIAL SECURITY NUMBER DATA QUALITY

Some projects may serve clients that do not have an SSN. In these cases, select 'Client doesn't know.'

Full SSN reported

Approximate or partial SSN reported

Client doesn't know

Client refused

#### DATE OF BIRTH (e.g., 10/23/1978)

		/			/				
Month			Day					Year	

#### DATE OF BIRTH TYPE

Use 01/01/YEAR and select 'approximate or partial date of birth' if client cannot recall DOB.

Full date of birth reported

Approximate or partial date of birth reported

Client doesn't know

Client refused

## DATA FOR ALL CLIENTS (CONTINUED)

### ETHNICITY

Non-Hispanic / Non-Latino

Hispanic / Latino

Client doesn't know

Client refused

### RACE

*More than one race is permitted. Client doesn't know and Client refused should only be selected if no other response is selected. If the client wishes to indicate "Hispanic or Latino," please indicate that in Ethnicity and then select the appropriate race category here.*

American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or Other Pacific Islander

White

Client doesn't know

Client refused

### GENDER

*Which of these genders best describes how the client identifies?*

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

*Is the client a veteran?*

*Veteran Status is only collected on heads of household who are 18 years of age and older, as well as all other adults in the household. A veteran is anyone who has ever been on active duty in the armed forces of the United States, regardless of discharge status or length of service.*

- For the **Army, Navy, Air Force, Marine Corps, and Coast Guard**, active duty begins when a military member reports to a duty station after completion of training.
- For the **Reserves and National Guard**, active duty is any time spent activated or deployed, either in the United States or abroad.
- Or Anyone who was disabled in the line of duty during a period of active duty training.
- Or Anyone who was disabled from an injury incurred in the line of duty or from acute myocardial infarction, a cardiac arrest, or a cerebrovascular accident during a period of inactive duty training.

No

Yes

Client doesn't know

Client refused

### RELATIONSHIP TO HEAD OF HOUSEHOLD

*In a household of a single individual, that person must be identified as the head of household. In multi-person households, one of person must be designated as the head of household and the rest must have their relationship to the head of household recorded. If the group of persons is composed of adults and children, an adult must be indicated as the 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

## 1. TYPE OF PRIOR LIVING SITUATION

What was the situation the client was living in immediately prior to project start?

Adult members of the same household may have different prior living situations

### 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

### Transitional & 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, no ongoing subsidy
- Rental by client, with VASH subsidy
- Rental by client, with GPD TIP subsidy
- Rental by client, with other ongoing housing subsidy
- 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)

### Other

- Client doesn't know
- Client refused

\*Interim housing is not a type of housing but rather a housing situation for a client that meets the following criteria:

1. Must have been chronically homeless at start in interim housing,
2. Must have applied for permanent housing, accepted, and have a unit/voucher for perm. hsg. reserved for them,
3. Must have been prevented from immediately accessing permanent housing unit or using a voucher in a permanent housing unit (e.g. apartment getting painted, old tenant moving out, has a voucher but is looking for the unit, etc.), and
4. Client and transitional housing project must have determined that transitional housing is an acceptable option until permanent housing unit is ready for occupancy.

## 2. LENGTH OF STAY IN PRIOR LIVING SITUATION

How long was the client staying in that place?

If the client moved around, but in the same type of situation, include the total time in that type of situation. If the client moved around from one situation to another, only include the time in the situation selected.

- 1 night or less
- 2 to 6 nights
- 1 week+, but less than 1 month
- 1 mo+, but less than 90 days
- 90 days, but less than 1 year
- 1 year or longer
- Client doesn't know
- Client refused

Proceed to Question 3

- 1 night or less
- 2 to 6 nights
- 1 week+, but less than 1 month
- 1 mo+, but less than 90 days
- 90 days, but less than 1 year
- 1 year or longer
- Client doesn't know
- Client refused

Proceed to Question 3

Skip Questions 3, 4 and 5

- 1 night or less
- 2 to 6 nights
- 1 week, but less than 1 month
- 1 month, but less than 90 days
- 90 days, but less than 1 year
- 1 year or longer
- Client doesn't know
- Client refused

Proceed to Question 3

Skip Questions 3, 4 and 5

### 3. DATE THE CLIENT STARTED BEING HOMELESS THIS TIME

#### When did the client start staying on the streets,\*\* in emergency shelters, or in safe havens this time?

Determine the date of the last time the client had a place to sleep that was not on the streets, in an emergency shelter, or in a safe haven. As the client looks back, there may be breaks in their stay on the streets, shelters, or safe havens. The breaks are allowed to be included in the look back period to calculate the start date only if:

- The client moved continuously between the streets, shelters, or safe havens. The date would go back as far as the first time they stayed in one of those places; OR
- The break in their time on the streets, shelters, or safe havens was less than 7 nights. A break is considered 6 or less consecutive nights not residing in a place not meant for human habitation, in shelter or in a safe haven. The look back time would not be broken by a stay less than 7 consecutive nights; OR
- The break in their time on the streets, ES, or SH was less than 90 days in any of the places listed under the header “institutional situations” on the previous page. The look back time would include all of those days (up to 89 days) when looking back for the start date.

If this is the client’s first day on the streets, shelters, or safe havens, enter today’s date.

\*\* “The streets” is being used as short-hand for any place unfit for human habitation (a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground).

		/			/			
Month			Day			Year		

### 4. NUMBER OF TIMES THE CLIENT HAS BEEN HOMLESS IN THE PAST THREE YEARS

#### How many times has the client been homeless on the streets, in shelter, or in safe havens in the past three years, including this time?

Count the times a client has been homeless, separated by breaks, in the last three years. A break means at least 7 consecutive nights of not living on the street, in an emergency shelter, or Safe Haven or at least 90 days in any of the places listed under the header “institutional situations” on the previous page.

- |   |  |
|---|--|
| <input type="checkbox"/> One time (this time) | <input type="checkbox"/> Four or more times  |
| <input type="checkbox"/> Two times            | <input type="checkbox"/> Client doesn’t know |
| <input type="checkbox"/> Three times          | <input type="checkbox"/> Client refused      |

### 5. TOTAL NUMBER OF MONTHS THE CLIENT HAS BEEN HOMLESS IN THE PAST THREE YEARS

#### How many months, in total, has the client has been homeless on the street, in an emergency shelter, or Safe Haven over the past three years?

Add up the total number of months homeless of all the different times the client has spent homeless on the streets, in shelter, or in safe havens in the past three years. Include any time a client spent in an institution for a period of less than 90 days or time spent in permanent or transitional housing for a period of less than 7 days. Responses may be rounded to the next-highest number of full months. The current month, even if a partial month, can be counted as a full month.

**Example:** The client has a project start date in an ES of March 15<sup>th</sup>. The client has been on the streets since January 15 and was in permanent housing prior to that, except for a two month period last year. The cumulative total would be 4.5 months (Last year = 2 months; January = 15 days, February = 1 month, March = 1 month). Enter 5 months where indicated.

- |  |   |
|--|---|
| <input type="checkbox"/> One month or less (choose if this is the first time the client has been homeless) |   |
| <input type="checkbox"/> Between 2 and 12 months →   | Enter the total number of months: _____ |
| <input type="checkbox"/> More than 12 months   |   |
| <input type="checkbox"/> Client doesn’t know   |   |
| <input type="checkbox"/> Client refused  |   |

**Homelessness Primary Reason:**

- |  |  |
|--|--|
| <input type="checkbox"/> Addiction               | <input type="checkbox"/> Jail/Prison                 |
| <input type="checkbox"/> Divorce                 | <input type="checkbox"/> Relationship Problems       |
| <input type="checkbox"/> Domestic Violence       | <input type="checkbox"/> Substandard Housing         |
| <input type="checkbox"/> Evicted                 | <input type="checkbox"/> Unable to Pay Rent/Mortgage |
| <input type="checkbox"/> Family/Personal Illness | <input type="checkbox"/> Unemployment                |
| <input type="checkbox"/> Fire                    | <input type="checkbox"/> Other: _____                |

**Homelessness Secondary Reason:**

- |   |  |
|---|--|
| <input type="checkbox"/> Addiction                      | <input type="checkbox"/> Jail/Prison                 |
| <input type="checkbox"/> Divorce                        | <input type="checkbox"/> Relationship Problems       |
| <input type="checkbox"/> Domestic Violence              | <input type="checkbox"/> Substandard Housing         |
| <input type="checkbox"/> Evicted                        | <input type="checkbox"/> Unable to Pay Rent/Mortgage |
| <input type="checkbox"/> Family/Personal Illness        | <input type="checkbox"/> Unemployment                |
| <input type="checkbox"/> Fire                           | <input type="checkbox"/> Other: _____                |
| <input type="checkbox"/> No Secondary Reason for Crisis |  |

**LAST PERMANENT ADDRESS (Prior to Homelessness)**

**Zip Code:**

- |  |  |
|--|--|
| <input type="checkbox"/> Enter Zip:      | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Outside of Ohio | <input type="checkbox"/> Client refused      |

**General Area Location:**

- |   |  |
|---|--|
| <input type="checkbox"/> Within Franklin County/ Outside City of Columbus | <input type="checkbox"/> Within Franklin County/ within City of Columbus   |
| <input type="checkbox"/> Outside Franklin County/ within City of Columbus | <input type="checkbox"/> Outside Franklin County/ Outside City of Columbus |
| <input type="checkbox"/> Outside of Ohio                                  | <input type="checkbox"/> Client Refused/ Doesn't Know                      |

**MENTAL HEALTH LINKAGE**

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

- |  |
|--|
| <input type="checkbox"/> Not currently linked but NEEDS linkage      |
| <input type="checkbox"/> Not currently linked, does NOT need linkage |

**DISABLING CONDITION**

Does the client currently have a disabling condition?

A disabling condition is any of the below-indicated disabilities or any other physical, mental, or emotional impairment (including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury) that is expected to be of long-continued and indefinite duration and substantially impairs ability to live independently.

<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> 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?
<input type="checkbox"/>	<input type="checkbox"/>	Physical Disability	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused
<input type="checkbox"/>	<input type="checkbox"/>	Developmental Disability	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Health Condition	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused
<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused
<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Problem	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused
<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse: <input type="checkbox"/> Drug <input type="checkbox"/> Alcohol <input type="checkbox"/> Both Drug & Alcohol	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused
<input type="checkbox"/>	<input type="checkbox"/>	Other If Yes, specify source: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused

**Pregnant?:**

<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> Client refused



**Projected Due Date:**

		/			/				
Month	Day		Year						

**DOMESTIC VIOLENCE**

Is client a domestic violence victim/survivor?

No

Yes

Client doesn't know

Client refused



**[IF YES] When did the experience occur?**

Within the past three months

Three to six months ago (excluding six months exactly)

Six months to one year ago (excluding one year exactly)

One year ago or more

Client doesn't know

Client refused

**[IF YES] Is the client currently fleeing?**

No

Yes

Client doesn't know

Client refused

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

**EMPLOYMENT INFORMATION**

**Employed?**

Client refused

Yes # of Hours/week: \_\_\_\_\_

Client doesn't know

No



Full-time

Part-time

Seasonal/Sporadic (including day labour)

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.**

*If the response for a source is 'Yes', enter the monthly amount received based on current income. If unsure of the exact monthly amount, enter client's best estimate. Answer 'No' for sources that have been terminated, even if they were received in the past.*

Source of income	Receiving income from source?	If yes, monthly amount from source (round to nearest dollar)		
Earned income (i.e., employment income)	No <input type="checkbox"/>			
	Yes <input type="checkbox"/>	\$		. 0 0
Unemployment Insurance	No <input type="checkbox"/>			
	Yes <input type="checkbox"/>	\$		. 0 0
Supplemental Security Income (SSI)	No <input type="checkbox"/>			
	Yes <input type="checkbox"/>	\$		. 0 0
Social Security Disability Insurance (SSDI)	No <input type="checkbox"/>			
	Yes <input type="checkbox"/>	\$		. 0 0
VA Service-Connected Disability Compensation	No <input type="checkbox"/>			
	Yes <input type="checkbox"/>	\$		. 0 0
VA Non-Service-Connected Disability Pension	No <input type="checkbox"/>			
	Yes <input type="checkbox"/>	\$		. 0 0
Private disability insurance	No <input type="checkbox"/>			
	Yes <input type="checkbox"/>	\$		. 0 0
Worker's Compensation	No <input type="checkbox"/>			
	Yes <input type="checkbox"/>	\$		. 0 0
Temporary Assistance for Needy Families (TANF)	No <input type="checkbox"/>			
	Yes <input type="checkbox"/>	\$		. 0 0
General Assistance (GA)	No <input type="checkbox"/>			
	Yes <input type="checkbox"/>	\$		. 0 0
Retirement Income from Social Security	No <input type="checkbox"/>			
	Yes <input type="checkbox"/>	\$		. 0 0
Pension or retirement income from a former job	No <input type="checkbox"/>			
	Yes <input type="checkbox"/>	\$		. 0 0
Child support	No <input type="checkbox"/>			
	Yes <input type="checkbox"/>	\$		. 0 0
Alimony or other spousal support	No <input type="checkbox"/>			
	Yes <input type="checkbox"/>	\$		. 0 0
Other source If yes, specify source: _____	No <input type="checkbox"/>			
	Yes <input type="checkbox"/>	\$		. 0 0
<b>Total monthly income from all sources</b>		<b>\$</b>		<b>. 0 0</b>



**NON-CASH BENEFITS**

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

*Only record regular, recurrent sources that are current as of today (not terminated). If a non-cash benefit is only received by a minor member of the household, record under the Head of Household's information.*

No
  Client doesn't know  
 Yes
  Client refused



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

Source of income	Receiving Benefits from source?	
Supplemental Nutrition Assistance Program (SNAP)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
TANF Child Care services (or use local name)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
TANF transportation services (or use local name)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Other TANF-Funded Services (or use local name)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Other source If yes, specify source: _____	No <input type="checkbox"/>	Yes <input type="checkbox"/>

**HEALTH INSURANCE**

*Is the client currently covered by health insurance?*

No
  Client doesn't know  
 Yes
  Client refused



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

*Answer 'No' for sources that have been terminated, even if they were received in the past.*

No	Yes	Source
<input type="checkbox"/>	<input type="checkbox"/>	Medicaid
<input type="checkbox"/>	<input type="checkbox"/>	Medicare
<input type="checkbox"/>	<input type="checkbox"/>	State Children's Health Insurance Program (or use local name)
<input type="checkbox"/>	<input type="checkbox"/>	Veteran's Administration (VA) Medical Services
<input type="checkbox"/>	<input type="checkbox"/>	Employer-Provided Health Insurance
<input type="checkbox"/>	<input type="checkbox"/>	Health insurance obtained through COBRA
<input type="checkbox"/>	<input type="checkbox"/>	Private Pay Health Insurance
<input type="checkbox"/>	<input type="checkbox"/>	State Health Insurance for Adults (or use local name)
<input type="checkbox"/>	<input type="checkbox"/>	Indian Health Services Program
<input type="checkbox"/>	<input type="checkbox"/>	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:**

		/			/			
Month			Day			Year		

**End Date:**

		/			/			
Month			Day			Year		

**Received Vocational Training?**

No

Yes

Client doesn't know

Client refused

**MILITARY INFORMATION**

**Entered Military Service:**

		/			/			
Month			Day			Year		

**Separated from Military Service:**

		/			/			
Month			Day			Year		

**Military Branch:**

**Discharge Status:**

Operation	Has the client participated in the following military operations?
World War II	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused
Korean War	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused
Vietnam War	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused
Persian Gulf War	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused
Afghanistan	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused
Iraqi Freedom	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused
Iraqi Dawn	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused
Other Peace-keeping Operations or Military Interventions:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused

**CHILD EDUCATION (for PSH, TH, SPC, VASH and Stable Families ONLY)**

**Child Presently Attending School?:**

No

Yes

Client doesn't know

Client refused

**If no, date last enrolled in school:**

		/			/				
--	--	---	--	--	---	--	--	--	--

Month

Day

Year

**If child has changed schools, was this planned?:**

No

Yes

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_