HMIS Data Collection Form for Project START – All Project Types

This form can be used by all project types.

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 CHILD 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

			-			-				

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

		/			/				

Month Day Year

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 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	☐	Client doesn't know
☐	Hispanic / Latino	☐	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	☐	White
☐	Asian	☐	Client doesn't know
☐	Black or African American	☐	Client refused
☐	Native Hawaiian or Other Pacific Islander		

GENDER

Which of these genders best describes how the client identifies?

☐	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

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	☐	Client doesn't know
☐	Yes	☐	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 other relation member (other relation to head of household)
☐	Head of household's child	☐	Other: non-relation member
☐	Head of household's spouse or partner		

--*Begin HIPAA Assessment*--

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.

☐	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

Pregnant?:

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

Projected Due Date:

		/			/				

Month Day Year

--*End HIPAA Assessment*--

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
☐	☐	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: ______________________

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

Child Presently Attending School?:

☐	No	☐	Client doesn't know
☐	Yes	☐	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:**________________