HMIS Intake Form

Please answer all questions. Fill out one form for each family member at program entry.

Intake Date: _____/_____/_____ **Referring Agency:** _____ **LOS at Facility:** _____

Name of Staff Person Completing Intake: _____

Phone Number & E-Mail Address of On-Going Staff Contact: _____

Legal First Name: _____ **Legal Middle Name**: _____

Legal Last Name: _____ **Suffix:** _____

Name Data quality: ❑ Full name reported ❑ Partial, street name, or code name reported ❑ Client Doesn't Know ❑ Client Refused

Alias (Preferred Name): First Name: _____ **Last Name:** _____

Social Security #: _____ – _____ – _____ ❑ Full ❑ Approximate or Partial ❑Client Doesn't Know ❑ Client Refused

Date of Birth (mm/dd/yyyy): _____/_____/_____❑ Full ❑ Approximate or Partial ❑Client Doesn't Know ❑ Client Refused

Race *(choose all that apply)*:	❑ White ❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander ❑ Black or African American ❑ Asian ❑Client doesn't know ❑Client refused
Ethnicity:	❑ Non-Hispanic/Non-Latino ❑ Hispanic/Latino ❑Client doesn't know ❑Client refused
Gender:	❑ Male ❑ Female ❑ Transgender Male to Female ❑ Transgender Female to Male ❑Other_____ ❑Client doesn't know ❑Client refused
Veteran Status	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Relationship to Head of Household:	❑Self (Head of Household) Head of Household's: ❑Child ❑ Spouse or Partner ❑Other relation member ❑Other Non-relation
Family Type:	❑Unaccompanied (Adult or Youth) ❑ Adult No Children ❑ Single Parent ❑ Two Parents
Current Marital Status (choose one)**:**	❑ Married ❑ Single ❑ Separated ❑ Widowed ❑ Divorced ❑ Living Together ❑ Never Married/Annulled ❑ Unknown ❑ Domestic Partner ❑ Common Law
Health Insurance:	❑ None ❑ Medicaid ❑ Medicare ❑State Health Insurance for Adults ❑ VA Medical Insurance ❑ Private Pay Health Insurance ❑Employer-Provided Health Insurance ❑ Health Insurance Obtained by COBRA ❑State Children's Health Insurance Program ❑ Client Doesn't Know ❑ Client Refused ❑ Other _____

Are you a survivor of domestic or intimate partner violence: ❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused

If you experienced domestic or intimate partner violence, how long ago did you have this experience?

❑ Within the past 3 months ❑ 3 to 6 months ago (excluding 6 months exactly) ❑ 6 to 12 months ago (excluding 12 months exactly)

❑ One year ago or more ❑ Client Doesn't Know ❑ Client Refused

Are you currently fleeing: ❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused

Housing Status:

❑ Homeless ❑ At imminent risk of losing housing ❑ Homeless under other federal statues ❑ Fleeing domestic violence

❑ At-risk of homelessness ❑ Stably housed ❑ Client doesn't know ❑ Client refused

HEALTH INFORMATION

Do you have a disabling condition?	❑ **Yes**	❑ **No**	❑ **Client Doesn't Know**	❑ **Client Refused**
Do you have a physical disability?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
If yes, is it expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
If yes, is there documentation of the disability and its severity on file?	❑ Yes	❑ No		
If yes, are you currently receiving services or treatment for this condition?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
Do you have a developmental disability?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
If yes, is it expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
If yes, is there documentation of the disability and its severity on file?	❑ Yes	❑ No		
If yes, are you currently receiving services or treatment for this condition?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
Do you have a chronic health condition?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
If yes, is it expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
If yes, is there documentation of the disability and its severity on file?	❑ Yes	❑ No		
If yes, are you currently receiving services or treatment for this condition?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
Have you been diagnosed with AIDS or have you tested positive for HIV?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
If yes, is it expected to substantially impair your ability to live independently?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
If yes, is there documentation of the disability and its severity on file?	❑ Yes	❑ No		
If yes, are you currently receiving services or treatment for this condition?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
Do you feel that you have a mental health problem?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
If yes, is it expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
If yes, is there documentation of the disability and its severity on file?	❑ Yes	❑ No		
If you have a mental health problem: Are you currently receiving services or treatment for this condition?	❑ Yes	❑ No	❑ Client Doesn't Know	❑ Client Refused
Mental Health: If yes for condition how confirmed?	❑Unconfirmed; presumptive or self-report	❑ Confirmed through assessment and clinical evaluation	❑ Confirmed by prior evaluation or clinical records	
Mental Health: Serious mental illness (SMI) and if SMI how confirmed?	❑ Unconfirmed; presumptive or self- report	❑ Confirmed by prior evaluation or clinical records	❑ Confirmed by prior evaluation or clinical records	❑ Client Doesn't Know ❑Client Refused
Do you have a substance abuse problem?	❑ Alcohol ❑ Drug ❑ Both Alcohol & Drug	❑ No	❑ Client Doesn't Know	❑ Client Refused
If yes, is it expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?	❑ Yes	❑ No	❑ Client Doesn't	❑ Client Refused
If yes, is there documentation of the disability and severity on file?	❑ Yes	❑ No	Know	
If yes, are you currently receiving services or treatment for this condition?	❑ Yes	❑ No	❑ Client Doesn't	❑ Client Refused
Substance Abuse: If yes for condition how confirmed?	❑Unconfirmed; presumptive or self-report	❑ Confirmed through assessment and clinical evaluation	❑ Confirmed by prior evaluation or clinical records	

SOURCE OF INCOME	Currently Receiving?		Gross Monthly Amount	Start Date
Earned Income	❑YES	❑NO		
General Assistance	❑YES	❑NO		
Alimony/Spousal Support	❑YES	❑NO		
Child Support	❑YES	❑NO		
TANF	❑YES	❑NO		
Unemployment Insurance	❑YES	❑NO		
SSI	❑YES	❑NO		
SSDI	❑YES	❑NO		
Retirement from Social Security	❑YES	❑NO		
VA Non-Service Connected Disability Pension	❑YES	❑NO		
VA Service Connected Disability Compensation	❑YES	❑NO		
Pension or Retirement Income from a Former Job	❑YES	❑NO		
Worker's Compensation	❑YES	❑NO		
Private Disability Insurance	❑YES	❑NO		
Other _____	❑YES	❑NO		

SOURCE OF NON-CASH BENEFIT	Currently Receiving?		Gross Monthly Amount	Start Date
Supplemental Nutrition Assistance Program (Food Stamps)	❑YES	❑NO		
Special Supplemental Nutrition Program for WIC	❑YES	❑NO		
TANF Child Care Services	❑YES	❑NO		
TANF Transportation Services	❑YES	❑NO		
Other TANF-Funded Services	❑YES	❑NO		
Section 8, Public Housing or other on-going rental assistance	❑YES	❑NO		
Temporary Rental Assistance	❑YES	❑NO		
Other _____	❑YES	❑NO		

RESIDENCE PRIOR TO PROGRAM ENTRY: CHOOSE ONE	
❑ Emergency Shelter (including hotel or motel paid for with emergency shelter funds)	❑ Rental by client, no on-going housing subsidy
❑ Foster care home or foster care group home	❑ Rental by client, with VASH subsidy
❑ Hospital or other residential non-psychiatric medical facility	❑ Rental by client, with GPD TIP subsidy
❑ Hotel or motel paid for without emergency shelter voucher	❑ Rental by client, with other on-going housing subsidy
❑ Interim housing	❑ Residential project or halfway house with no homeless criteria
❑ Jail, prison or juvenile detention facility	❑ Safe Haven
❑ Long-term care facility or nursing home	❑ Staying or living in a family member's room, apartment or house
❑ Owned by client, no housing subsidy	❑ Staying or living in a friend's room, apartment or house
❑ Owned by client, with on-going housing subsidy	❑ Substance abuse treatment facility or detox facility
❑ Permanent housing for formerly homeless persons (such as: CoC projects, HUD legacy programs; or HOPWA PH)	❑ Transitional housing for homeless persons (including homeless youth)
❑ Place not meant for human habitation	❑ Client doesn't know
❑ Psychiatric hospital or other psychiatric facility	❑ Client refused

LENGTH OF STAY IN PRIOR LIVING SITUATION (LENGTH OF STAY FROM PREVIOUS QUESTION): CHOOSE ONE	
❑ One day or less	❑ 90 days or more, but less than on 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

Last Known Address (where you last lived for 90 days or more):

Street Address Apt. # City State ZIP

NUMBER OF TIMES CLIENT HAS BEEN HOMELESS ON STREETS, EMERGENCY SHELTER OR SAFE HAVENIN THE PAST THREE (3) YEARS:	
❑ One time	❑ Four or more times
❑ Two times	❑ Client doesn't know
❑ Three times	❑ Client refused

TOTAL NUMBER OF MONTHS HOMELESS ON THE STREETS, EMERGENCY SHELTER OR SAFE HAVEN IN THE PAST THREE (3) YEARS:			
❑ 1 (this time is the first month)	❑ 5	❑ 9	❑ More than 12 months
❑ 2	❑ 6	❑ 10	❑ Other: _____
❑ 3	❑ 7	❑ 11	❑ Client doesn't know
❑ 4	❑ 8	❑ 12	❑ Client refused

Approximate Date of Homelessness Starting? _____

If you have a current behavioral healthcare case manager, please list their information below:

Case Manager: _____ Agency: _____

Phone Number: _____

By **initialing and signing** this document, I am certifying the following:

_____I have answered the questions truthfully and to the best of my ability.

_____I understand that my referral information will be sent to the Broward Behavioral Health Coalition for evaluation and referral.

_____I understand that my information may be entered into Broward County's Homeless Management Information System (HMIS).

_____I understand that the Broward Behavioral Health Coalition will use the releases of information that I sign to refer me to an appropriate housing program, link me to supportive services and communicate with my providers to track my stay at a facility and assist in discharge planning.

_____I understand that Broward County Homeless Initiative Partnership (HIP) manages the entire homeless housing system of care and any housing referrals must be processed according to their Coordinated Entry and Housing Placement standards.

_____If I do not meet the criteria for HUD-funded programs, the Broward Behavioral Health Coalition may refer me to homeless prevention programs or work with my service providers to access a different level of care, if needed.

_____I understand that these programs and supportive services offered to me are voluntary.

_____This referral does not guarantee I will receive housing assistance.

_____ _____

Signature **Date**

_____

Printed Name