

**CMIS/HMIS Intake Form**  
**Agency or Event Name**

Any individual with a disability or other medical need who needs accommodation with respect to this form should inform **(Designated Person/Agency)**.

**Date Intake Form Completed (Assessment Date):** \_\_\_\_\_

**Section 1: Household**

- A. Household Type:** Select the household type that best describes your household. Please select only one.
- Single Individual       Female Single Parent       Male Single Parent       Two Parent Family  
 Grandparent(s) and Child(ren)       Foster Parent(s)       Couple with No Children       Non-Custodial Caregivers  
 Other (explain): \_\_\_\_\_

**B. Household Demographics.** Starting with the Head of the Household, list all members of the household. Use the correct legal name for each member as it appears on his/her Social Security Card or INS documents.

Name Last, First, Middle And Social Security Number	Relation to Head of Household	Date of Birth	Gender	Race* (Select as many as apply)	Ethnicity*	HUD Certified Disability (Yes/No)	Disability Type* (if applicable)	Health Insurance Information
____ - ____ - ____ -or- <input type="checkbox"/> I don't know or don't have one <input type="checkbox"/> I choose not to provide	Head of the Household		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans- gender M to F <input type="checkbox"/> Trans- gender F to M <input type="checkbox"/> Other	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African- American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> White	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non- Hispanic	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Drug Abuse <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Illness <input type="checkbox"/> Physical <input type="checkbox"/> Chronic Health Cond. <input type="checkbox"/> Other disability not listed <input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> State Insurance/Child <input type="checkbox"/> VA Med Services <input type="checkbox"/> Employer-Provided <input type="checkbox"/> COBRA <input type="checkbox"/> State Insurance/Adults <input type="checkbox"/> Private Pay <input type="checkbox"/> Not insured
____ - ____ - ____ -or- <input type="checkbox"/> I don't know or don't have one <input type="checkbox"/> I choose not to provide			<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans- gender M to F <input type="checkbox"/> Trans- gender F to M <input type="checkbox"/> Other	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African- American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> White	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non- Hispanic	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Drug Abuse <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Illness <input type="checkbox"/> Physical <input type="checkbox"/> Chronic Health Cond. <input type="checkbox"/> Other disability not listed <input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> State Insurance/Child <input type="checkbox"/> VA Med Services <input type="checkbox"/> Employer-Provided <input type="checkbox"/> COBRA <input type="checkbox"/> State Insurance/Adults <input type="checkbox"/> Private Pay <input type="checkbox"/> Not insured
____ - ____ - ____ -or- <input type="checkbox"/> I don't know or don't have one <input type="checkbox"/> I choose not to provide			<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans- gender M to F <input type="checkbox"/> Trans- gender F to M <input type="checkbox"/> Other	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African- American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> White	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non- Hispanic	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Drug Abuse <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Illness <input type="checkbox"/> Physical <input type="checkbox"/> Chronic Health Cond. <input type="checkbox"/> Other disability not listed <input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> State Insurance/Child <input type="checkbox"/> VA Med Services <input type="checkbox"/> Employer-Provided <input type="checkbox"/> COBRA <input type="checkbox"/> State Insurance/Adults <input type="checkbox"/> Private Pay <input type="checkbox"/> Not insured
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\* This information is voluntary and is used for statistical purposes only.

Please continue to the next page ➡

## Section 2: Contact Information

Mailing Address: \_\_\_\_\_  
 (Street Address and Apartment, or PO Box)

\_\_\_\_\_  
 (City) (State) (Zip)

Telephone: \_\_\_\_\_ Email Address: \_\_\_\_\_

## Section 3: Household Income and Benefits

### A. Income and Cash Benefits

Has any member of the household received any **income or cash benefits** in the last 30 days? .....  Yes  No

If yes, please indicate the monthly amount from each of the following sources:

Income Type	Monthly Amount	Who?	Approx. Date Income Began	Income Type	Monthly Amount	Who?	Approx. Date Income Began
Alimony or Spousal Support	\$	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____		Social Security	\$	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____	
Child Support	\$	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____		SSDI	\$	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____	
Earned Income	\$	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____		SSI	\$	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____	
General Assistance	\$	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____		TANF	\$	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____	
Pension	\$	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____		Unemployment	\$	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____	
Private Disability Insurance	\$	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____		Veteran's Non-Svc. Disability Pension	\$	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____	
Other:	\$	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____		Veteran's Svc. Disability Comp	\$	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____	
Other:	\$	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____		Worker's Compensation	\$	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____	

### B. Non-Cash Benefits

Has any member of the household received any **non-cash benefits** in the last 30 days? .....  Yes  No

If yes, please indicate the monthly amount from each of the following sources:

Benefit Type	Monthly Amount, if known	Who?	Approx. Date Benefit Began	Benefit Type	Monthly Amount, if known	Who?	Approx. Date Benefit Began
Food Stamps (aka "SNAP")	\$	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____		Other TANF-Funded Services	\$	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____	
Spec. Supp. Nutrition, aka WIC	\$	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____		Rental Subsidy (Section 8, HUD)	\$	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____	
TANF Child Care Services	\$	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____		Temporary Rental Assistance	\$	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____	
TANF Transportation Services	\$	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____		Other:	\$	<input type="checkbox"/> Head of Household <input type="checkbox"/> Other: _____	

Are you a victim of Domestic Violence? .....  Yes  No  Prefer not to answer

If so, how long ago? ..... \_\_\_\_\_ or  Prefer not to answer

Are you fleeing Domestic Violence? .....  Yes  No  Prefer not to answer

Are you a US Military Veteran? .....  Yes  No  Prefer not to answer

Are any other household members Veterans? .....  Yes  No  Prefer not to answer

If so, who? \_\_\_\_\_

Please continue to the next page ➡

## Section 4: Housing Status and Other Demographics

A. Where have you been living or staying up until today? Please check one:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Emergency Shelter (including hotel/motel voucher)<br><input type="checkbox"/> Seasonal/Winter shelter? | <input type="checkbox"/> Owned by me<br><input type="checkbox"/> With Subsidy or <input type="checkbox"/> Without Subsidy   | <input type="checkbox"/> Residential Project/Halfway House that doesn't require homelessness |
| <input type="checkbox"/> Foster Care Home or Group Home   | <input type="checkbox"/> Permanent Housing for Formerly Homeless Persons  | <input type="checkbox"/> Safe Haven  |
| <input type="checkbox"/> Hospital (Non-Psychiatric)   | <input type="checkbox"/> Place not meant for Habitation   | <input type="checkbox"/> Staying with Family   |
| <input type="checkbox"/> Hotel or Motel Paid Without Emergency Shelter Voucher  | <input type="checkbox"/> Psychiatric Hospital or Facility   | <input type="checkbox"/> Staying with Friends  |
| <input type="checkbox"/> Jail, Prison, or Juvenile Facility   | <input type="checkbox"/> Rental by me<br><input type="checkbox"/> With VASH Housing Subsidy or<br><input type="checkbox"/> With GPD TIP Housing Subsidy<br><input type="checkbox"/> With Other Housing Subsidy (i.e. Section 8)<br><input type="checkbox"/> Without Subsidy | <input type="checkbox"/> Substance Abuse Treatment Facility                                  |
| <input type="checkbox"/> Long Term Care Facility  |   | <input type="checkbox"/> Transitional Housing  |
| <input type="checkbox"/> Other:<br>_____  |   | <input type="checkbox"/> Don't know  |
|   |   | <input type="checkbox"/> Prefer not to answer  |

B. How long have you been staying in the situation above?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> One week or less                        | <input type="checkbox"/> One to three months                          | <input type="checkbox"/> One year or longer |
| <input type="checkbox"/> More than a week, but less than a month | <input type="checkbox"/> More than three months, but less than a year | Approx. date became homeless _____          |

C. How many times have you been on streets, in Emerg. Shelter or Safe Haven in the past 3 years? \_\_\_\_\_

D. Total months on streets, in Emerg. Shelter or Safe Haven in the past 3 years \_\_\_\_\_

E. Can your homelessness be documented by a third party?  Yes  No  Don't know

F. What is/was the zip code of your last permanent address? \_\_\_\_\_  Don't know

G. Are you/your household currently homeless?  Yes  No

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## Notice of Use

**Agency or Event Name** provides services through a variety of funding sources, which may include government grants, public funds, or grants from private foundations. **Agency or Event Name** is required to collect and report on certain information to account for how these funds are used. In addition, this information may aid the effort to end homelessness by demonstrating how many individuals and families in the area need services.

For this reason, you have been asked to provide the information on this form. The information you have provided will be entered into a Homeless Management Information System (HMIS) and used to provide statistical information about services provided to homeless persons (or persons at risk of homelessness) in Washington County and the metropolitan area.

Your identifying information will be kept as confidential as possible: it will only be seen by persons supervised by **Agency or Event Name**, persons in other agencies to which you may be referred for further assistance, and persons administering or auditing the HMIS. All agencies and individuals with access to HMIS must adhere to strictly regulated and controlled confidentiality requirements.

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Signature of the Head of the Household

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Date

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Spouse/Other Adult

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Date