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- ☐ I don't know or don't have one ☐ I choose not to provide	Head of the Household		☐Male ☐Female ☐Trans-gender M to F ☐Trans-gender F to M ☐ Other	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African-American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ White	☐Hispanic ☐Non-Hispanic	☐Yes ☐No	☐ Alcohol Abuse ☐ Developmental Disability ☐ Drug Abuse ☐ HIV/AIDS ☐ Mental Illness ☐ Physical ☐ Chronic Health Cond. ☐ Other disability not listed ☐ Prefer not to answer	☐ MEDICAID ☐ MEDICARE ☐ State Insurance/Child ☐ VA Med Services ☐ Employer-Provided ☐ COBRA ☐ State Insurance/Adults ☐ Private Pay ☐ Not insured
______ -_____ -_______ -or- ☐ I don't know or don't have one ☐ I choose not to provide			☐Male ☐Female ☐Trans-gender M to F ☐Trans-gender F to M ☐ Other	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African-American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ White	☐Hispanic ☐Non-Hispanic	☐Yes ☐No	☐ Alcohol Abuse ☐ Developmental Disability ☐ Drug Abuse ☐ HIV/AIDS ☐ Mental Illness ☐ Physical ☐ Chronic Health Cond. ☐ Other disability not listed ☐ Prefer not to answer	☐ MEDICAID ☐ MEDICARE ☐ State Insurance/Child ☐ VA Med Services ☐ Employer-Provided ☐ COBRA ☐ State Insurance/Adults ☐ Private Pay ☐ Not insured
______ -_____ -_______ -or- ☐ I don't know or don't have one ☐ I choose not to provide			☐Male ☐Female ☐Trans-gender M to F ☐Trans-gender F to M ☐ Other	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African-American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ White	☐Hispanic ☐Non-Hispanic	☐Yes ☐No	☐ Alcohol Abuse ☐ Developmental Disability ☐ Drug Abuse ☐ HIV/AIDS ☐ Mental Illness ☐ Physical ☐ Chronic Health Cond. ☐ Other disability not listed ☐ Prefer not to answer	☐ MEDICAID ☐ MEDICARE ☐ State Insurance/Child ☐ VA Med Services ☐ Employer-Provided ☐ COBRA ☐ State Insurance/Adults ☐ Private Pay ☐ Not insured
______ -_____ -_______ -or- ☐ I don't know or don't have one ☐ I choose not to provide			☐Male ☐Female ☐Trans-gender M to F ☐Trans-gender F to M ☐ Other	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African-American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ White	☐Hispanic ☐Non-Hispanic	☐Yes ☐No	☐ Alcohol Abuse ☐ Developmental Disability ☐ Drug Abuse ☐ HIV/AIDS ☐ Mental Illness ☐ Physical ☐ Chronic Health Cond. ☐ Other disability not listed ☐ Prefer not to answer	☐ MEDICAID ☐ MEDICARE ☐ State Insurance/Child ☐ VA Med Services ☐ Employer-Provided ☐ COBRA ☐ State Insurance/Adults ☐ Private Pay ☐ Not insured
______ -_____ -_______ -or- ☐ I don't know or don't have one ☐ I choose not to provide			☐Male ☐Female ☐Trans-gender M to F ☐Trans-gender F to M ☐ Other	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African-American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ White	☐Hispanic ☐Non-Hispanic	☐Yes ☐No	☐ Alcohol Abuse ☐ Developmental Disability ☐ Drug Abuse ☐ HIV/AIDS ☐ Mental Illness ☐ Physical ☐ Chronic Health Cond. ☐ Other disability not listed ☐ Prefer not to answer	☐ MEDICAID ☐ MEDICARE ☐ State Insurance/Child ☐ VA Med Services ☐ Employer-Provided ☐ COBRA ☐ State Insurance/Adults ☐ Private Pay ☐ Not insured
______ -_____ -_______ -or- ☐ I don't know or don't have one ☐ I choose not to provide			☐Male ☐Female ☐Trans-gender M to F ☐Trans-gender F to M ☐ Other	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African-American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ White	☐Hispanic ☐Non-Hispanic	☐Yes ☐No	☐ Alcohol Abuse ☐ Developmental Disability ☐ Drug Abuse ☐ HIV/AIDS ☐ Mental Illness ☐ Physical ☐ Chronic Health Cond. ☐ Other disability not listed ☐ Prefer not to answer	☐ MEDICAID ☐ MEDICARE ☐ State Insurance/Child ☐ VA Med Services ☐ Employer-Provided ☐ COBRA ☐ State Insurance/Adults ☐ Private Pay ☐ Not insured

* This information is voluntary and is used for statistical purposes only.

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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	$	☐ Head of Household ☐ Other:_________		Social Security	$	☐ Head of Household ☐ Other: _________	
Child Support	$	☐ Head of Household ☐ Other:_________		SSDI	$	☐ Head of Household ☐ Other:_________	
Earned Income	$	☐ Head of Household ☐ Other:_________		SSI	$	☐ Head of Household ☐ Other: _________	
General Assistance	$	☐ Head of Household ☐ Other:_________		TANF	$	☐ Head of Household ☐ Other: _________	
Pension	$	☐ Head of Household ☐ Other:_________		Unemployment	$	☐ Head of Household ☐ Other: _________	
Private Disability Insurance	$	☐ Head of Household ☐ Other:_________		Veteran's Non-Svc. Disability Pension	$	☐ Head of Household ☐ Other: _________	
Other: _________	$	☐ Head of Household ☐ Other: _________		Veteran's Svc. Disability.Comp	$	☐ Head of Household ☐ Other: _________	
Other: _________	$	☐ Head of Household ☐ Other: _________		Worker's Compensation	$	☐ Head of Household ☐ 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")	$	☐ Head of Household ☐ Other: _________		Other TANF-Funded Services	$	☐ Head of Household ☐ Other: _________	
Spec. Supp. Nutrition, aka WIC	$	☐ Head of Household ☐ Other: _________		Rental Subsidy (Section 8, HUD)	$	☐ Head of Household ☐ Other: _________	
TANF Child Care Services	$	☐ Head of Household ☐ Other: _________		Temporary Rental Assistance	$	☐ Head of Household ☐ Other: _________	
TANF Transportation Services	$	☐ Head of Household ☐ Other: _________		Other: _________	$	☐ Head of Household ☐ 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:

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

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

- ☐ Less than 7 days
- ☐ A week or more, but less than a month
- ☐ At least a month, but less than 90 days
- ☐ More than three months, but less than a year
- ☐ One year or longer

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

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.

______________________________________ ____________
Signature of the Head of the Household — Date

______________________________________ ____________
Spouse/Other Adult — Date