Client ID # _____

HMIS Data Collection Template – Client Entry (HUD)

This questionnaire is to be administered by case workers. Please fill out for EVERY household member at **entry.** All clients over 18 years old must sign the consent form for HMIS.

PROGRAM NAME:	
CASE MANAGER NAME:	
DATE OF DATA COLLECTION:	

Universal Data Elements

CLIENT NAME		
	First Name	
	Middle Name	
	Last Name	
	Suffix (if any)	
	Alias (if any)	
	☐Full Name Reported ☐Partial Name Reported ☐Client Doesn't Know ☐Client Refused	
SOCIAL SECURITY NUMBER	___ ___ ___ - ___ ___ - ___ ___ ___ ___ ☐Full SSN Reported ☐Partial or Approximate SSN Reported ☐Client Doesn't Know ☐Client Refused	
DATE OF BIRTH	___ ___ / ___ ___ / ___ ___ ___ ___ ☐Full DOB Reported ☐Partial or Approximate DOB Reported ☐Client Doesn't Know ☐Client Refused	
ARE YOU A VETERAN?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused	
ARE YOU DISBALED?	☐ Yes (**If Yes, see pg. 5.)** ☐ No	

RACE *(Mark a "1" for Primary Race, and "2" for Secondary Race, if no Secondary Race, that is okay).	____ American Indian or Alaskan Native ____ Asian ____ Black or African American ____ Native Hawaiian or Other Pacific Islander ____ White ____ Client Doesn't Know ____ Client Refused
ETHNICITY	☐ Non-Hispanic / Non-Latino ☐ Hispanic / Latino ☐ Client Doesn't Know ☐ Client Refused
GENDER *(Please ask the client this question, no observations.)	☐ Female ☐ Male ☐ Trans Female (Male to Female or MTF) ☐ Trans Male (Female to Male or FTM) ☐ Gender Non-Conforming (i.e. not exclusively male or female) ☐ Client Doesn't Know ☐ Client Refused
U.S. MILITARY VETERAN?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused
RELATIONSHIP TO HEAD OF HOUSEHOLD (If single adult, select 'Self'):	☐ Self – Head of Household ☐ Head of Household Spouse or Partner ☐ Head of Household's Child ☐ Other Relation to Head of Household ☐ Other: Non-Relation Member
HOUSING MOVE-IN DATE (IF HOUSED):	____ ____ /___ ___ / ___ ___ ___ ___

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Living Situation (Residence Prior to Project Entry)

Collection is required at entry for Heads of Household and adults entering HMIS project type: street outreach, emergency shelter & safe haven.

Please consider the question, "Where was the client sleeping the night before project entry?" Answer the questions accordingly then follow the instructions to the appropriate subsection.

WAS CLIENT LITERALLY HOMELESS?

☐ Yes

IF YES…

Please select the option that best describes your clients previous destination.

☐ A place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)
☐ An emergency shelter, including hotel or motel paid for with emergency shelter voucher
☐ Safe Haven
☐ Interim Housing

☐ No

If NO… please select option that best describes your clients previous destination

Institutional Situation

☐ Foster care home or foster care group home
☐ Long-term care facility or nursing home
☐ Hospital or other residential non-psychiatric medical facility
☐ Psychiatric hospital or other psychiatric facility
☐ Jail, prison or juvenile detention facility
☐ Substance abuse treatment facility or detox center

Transitional or Permanent Housing Situation

☐ Hotel or motel paid for without emergency shelter voucher
☐ Residential project or halfway house with no homeless criteria
☐ Owned by client, no ongoing housing subsidy
☐ Owned by client, with ongoing housing subsidy
☐ Permanent housing (other than RRH) for formerly homeless person
☐ Rental by client, no ongoing housing subsidy
☐ Rental by client, with VASH subsidy
☐ Rental by client, with GPD TIP subsidy
☐ Rental by client, with other housing subsidy (including RRH)
☐ 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)
☐ Client Doesn't Know

Client ID # _____

HMIS Data Collection Template – Client Entry (HUD)

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	☐ Client Refused	
WHAT WAS CLIENT'S **LENGTH OF STAY IN PRIOR LIVING SITUATION?**	☐ One night or less ☐ Two to six nights ☐ One week or more, but less than one month ☐ One month or more, but less than 90 days	☐ 90 days or more, but less than one year ☐ One year or longer ☐ Client Doesn't Know ☐ Client Refused
APPROXIMATE DATE HOMELESSNESS STARTED:		___ ___ / ___ ___ / ___ ___ ___ ___
REGARDLESS OF WHERE THE CLIENT STAYED LAST NIGHT, HOW MANY TIMES HAVE THEY BEEN HOMELESS ON THE STREET, IN ES OR SH IN THE PAST THREE (3) YEARS INCLUDING TODAY? (First, count the breaks in homelessness in order to determine the number of times homeless.)		☐ One time ☐ Two times ☐ Three Times ☐ Four or more times ☐ Client Doesn't Know ☐ Client Refused
WHAT IS THE CLIENT'S TOTAL NUMBER OF MONTHS HOMELESS ON THE STREET, IN ES OR SH IN THE PAST (3) YEARS? (Any amount of days in a month= 1 month. For example: If the client has been on the streets, ES, or SH since January and it is now March, the cumulative total would be 3 months (January = 1, February = 2, and March = 3). If the client was also homeless for a month back in October, the cumulative total would then be 4 months.)	☐One Month (this is the first month) ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months ☐ 7 months ☐ 8 months	☐ 9 months ☐ 10 months ☐ 11 months ☐ 12 months ☐ More than 12 months ☐ Client Doesn't Know ☐ Client Refused

Income and Sources (As of Project Entry)

Collection is required at entry for Heads of Household and all adults (over 18). Updates required for persons aging into adulthood.

Ask the client whether they receive income from EACH source listed instead of asking them to state the sources of income they receive. Income or benefits received by a minor child should be assigned to HOH.

Income from ANY source?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused *If Yes for "Income from ANY source," indicate all sources and dollar amounts for the source(s) that apply.*

Monthly Income (Cash) Source:		**Monthly Amount:**
Earned Income (i.e., employment income)	☐ No ☐ Yes	$
Unemployment Insurance	☐ No ☐ Yes	$
Supplemental Security Income (SSI)	☐ No ☐ Yes	$

HMIS Data Collection Template – Client Entry (HUD)

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Social Security Disability Income (SSDI)	☐ No ☐ Yes	$
VA Service-Connected Disability Compensation	☐ No ☐ Yes	$
VA Non-Service-Connected Disability Compensation	☐ No ☐ Yes	$
Private Disability Insurance	☐ No ☐ Yes	$
Workers Compensation	☐ No ☐ Yes	$
Temporary Assistance for Needy Families (TANF)	☐ No ☐ Yes	$
General Assistance (GA)	☐ No ☐ Yes	$
Retirement Income from Social Security	☐ No ☐ Yes	$
Pension/Retirement Income from Former Job	☐ No ☐ Yes	$
Child Support	☐ No ☐ Yes	$
Alimony or other Spousal Support	☐ No ☐ Yes	$
Other Source – SPECIFY HERE: _____	☐ No ☐ Yes	$
MONTHLY INCOME TOTAL:		**$**

Non-Cash Benefits (As of Project Entry)

Ask the client whether they receive income from EACH source listed instead of asking them to state the sources of income they receive.

Non-Cash Benefit from ANY source?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused *If Yes for "Non-Cash Benefit from ANY source," indicate all sources and dollar amounts for the source(s) that apply.*

Non-Cash Benefit Source:		**Monthly Amount:**
Supplemental Nutrition Assistance Program (SNAP)	☐ No ☐ Yes	$
Special Supplemental Nutrition Program (WIC)	☐ No ☐ Yes	$
TANF Child Care Services	☐ No ☐ Yes	$
TANF Transportation Services	☐ No ☐ Yes	$
Other TANF-Funded Services	☐ No ☐ Yes	$
Other Source – SPECIFY HERE: _____	☐ No ☐ Yes	$
MONTHLY NON-CASH BENEFITS TOTAL:		$

Health Insurance (As of Project Entry)

To be collected at entry for all clients, regardless of age.

Covered by Health Insurance?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused *If Yes for "Income from ANY source," indicate all sources and dollar amounts for the source(s) that apply.*

Health Insurance Source	Covered?
Medicaid (Low-Income Families or Individuals)	☐ No ☐ Yes
Medicare (65+ or Some Younger Clients With Disabilities)	☐ No ☐ Yes
State Children's Health Insurance Program; STATE: _____	☐ No ☐ Yes
Veterans Administration (VA) Medical Services	☐ No ☐ Yes
Employer-Provided Health Insurance	☐ No ☐ Yes
Health Insurance Obtained through COBRA	☐ No ☐ Yes

Client ID # _____

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Private Pay Health Insurance; SPECIFY: _____	☐ No ☐ Yes
State Health Insurance for Adults; STATE: _____	☐ No ☐ Yes
Indian Health Services Program	☐ No ☐ Yes
Other; SPECIFY: _____	☐ No ☐ Yes

Disability Status (As of Project Entry)			
To be collected at entry for all clients, regardless of age.			
Disability?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused *If Yes for "Disability," indicate type(s) and if it is expected to be of long-continued and indefinite duration and substantially impairs their ability to live independently.*		
Disability Type:		**Notes (Optional)**	**(If yes), is it expected to be of long –continued and indefinite duration and substantially impair ability to live independently?**
Physical Disability	☐ No ☐ Yes		☐ No ☐ Yes
Developmental Disability	☐ No ☐ Yes		☐ No ☐ Yes
Chronic Health Condition	☐ No ☐ Yes		☐ No ☐ Yes
HIV/AIDS	☐ No ☐ Yes		☐ No ☐ Yes
Mental Health Problem	☐ No ☐ Yes		☐ No ☐ Yes
Substance Use - Alcohol Abuse?	☐ No ☐ Yes		☐ No ☐ Yes
Drug Abuse?	☐ No ☐ Yes		☐ No ☐ Yes
Both Alcohol & Drug Abuse?	☐ No ☐ Yes		☐ No ☐ Yes

Domestic Violence (As of Project Entry)		
To be collected at entry for all clients, regardless of age.		
Domestic Violence Victim or Survivor?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused	
	IF 'YES': When did experience occur?	☐ Within the Past 3 Months ☐ 3-6 Months Ago ☐ 6 Months – 1 Year Ago ☐ 1 Year Ago or More
	Are you currently fleeing?	☐ No ☐ Yes