

SPOKANE HMIS CLIENT INTAKE FORM



City of Spokane
Human Services Department

July 2010

HMIS CLIENT INTAKE FORM

****Please complete a separate intake form for each individual family member.**

~Last Name: _____ ~First Name: _____ ~Suffix: _____
 ~SSN: _____ - - - - ~SSN type: Full SSN reported Partial SSN Reported Don't know or don't have SSN Refused
 ~Date of birth: ___/___/___ ~Birth date quality: Approximate or partial DOB reported Full DOB reported Don't know Refused
 ~Gender: Male Female Transgender Female to Male Transgender Male to Female Other Don't know Refused
 ~Pregnancy status: Yes** No Don't know Refused **If yes, due Date ___/___/___ ~Marital status: Single Never Married Divorced Married
 & Living w/ Spouse Married & Not Living w/ Spouse Common Law Living Together Widowed Other Civil Union ~Client type: Client Outreach

Family and Contact Information

~Family Name: _____ ~Relationship to head of household: Self Parent Son Daughter
 Dependent Child Grandparent Guardian Spouse Other Family Member Other Non-Family Other Caretaker Grandchild Step Child Significant
 Other (Non-Married) ~Mailing address: _____
 ~Zip code: _____ ~Home phone: _____ ~Emergency contact type: Guardian Other Relative Mentor Physician
 Best Friend Primary Care Giver ~Emergency contact name: _____
 ~Emergency contact phone: _____

Demographics

~Ethnicity: Hispanic/Latino Non-Hispanic/Latino Don't know Refused ~Race: American Indian or Alaska Native Asian Black or African
 American Native Hawaiian or Other Pacific Islander White Don't know Refused

Information Release and Security

~Security restriction: Restrict to Organization Share Intake to MOU/Info Release Share Intake globally

MASTER ASSESSMENT

~Assessment date: ___/___/___ ~Assessment type: Entry During Program Enrollment Exit Follow-up Quick Intake SMS After Care
 Follow-up Other ~Program name: _____
 ~Assessor name: _____ ~Restriction: Restrict to Org. Unrestricted

Universal Data Elements

~Assessment date: ___/___/___ ~Veteran status: No Yes Don't know Refused ~Disabling condition: No Yes Don't know
 Refused ~Residence prior to program entry: Emergency shelter Transitional housing for homeless persons Permanent housing for formerly
 homeless Psychiatric hospital Substance abuse treatment facility Hospital (non-psychiatric) Jail, prison or juvenile detention Rental by client, no
 subsidy Owned by client, no subsidy Staying or living in a family member's room, apartment or house Staying or living in a friend's room, apartment or
 house Hotel or motel Foster care Place not meant for habitation Other Safe Haven Rental, with VASH subsidy Rental, with other (non-VASH)
 subsidy Owned by client, with subsidy Don't Know Refused ~Length of stay: One week or less More than one week, but less than one month
 One to three months More than three months, but less than one year One year or longer Don't Know Refused ~Housing status: Literally
 Homeless Unstably Housed & at-risk of losing their housing Imminently losing their housing Doubled Up Don't Know Refused
 ~Prior zip: _____ ~City: _____ ~State: _____
 ~Prior zip quality: Full Zip Code Recorded Don't Know Refused ~Restriction: Restrict to Organization Unrestricted

Chronic Homeless Assessment

~Assessment date: ___/___/___ ~Unaccompanied individual: No Yes ~Continuously homeless for a year or more: No Yes
 ~4 episodes of homelessness in the past 3 years: No Yes ~Substance use disorder: No Yes ~Serious mental disability: No
 Yes ~Developmental disability: No Yes ~Chronic physical illness or disability: No Yes ~Chronically homeless: No Yes
 ~Restriction: Restrict to Org Unrestricted

Barriers

Barrier	Identified				Date Identified	Receiving Services/Treatment				Condition is Indefinite			
Alcohol Abuse	No	Yes	Don't Know	Refused	___/___/___	No	Yes	Don't Know	Refused	No	Yes	Don't Know	Refused
Developmental Disability	No	Yes	Don't Know	Refused	___/___/___	No	Yes	Don't Know	Refused	No	Yes	Don't Know	Refused
Domestic Violence	No	Yes	Don't Know	Refused	___/___/___	No	Yes	Don't Know	Refused	No	Yes	Don't Know	Refused
Chronic Health	No	Yes	Don't Know	Refused	___/___/___	No	Yes	Don't Know	Refused	No	Yes	Don't Know	Refused
Drug Abuse	No	Yes	Don't Know	Refused	___/___/___	No	Yes	Don't Know	Refused	No	Yes	Don't Know	Refused
Dually Diagnosed	No	Yes	Don't Know	Refused	___/___/___	No	Yes	Don't Know	Refused	No	Yes	Don't Know	Refused
HIV/AIDS	No	Yes	Don't Know	Refused	___/___/___	No	Yes	Don't Know	Refused	No	Yes	Don't Know	Refused
Mental Illness	No	Yes	Don't Know	Refused	___/___/___	No	Yes	Don't Know	Refused	No	Yes	Don't Know	Refused
Physical Disability	No	Yes	Don't Know	Refused	___/___/___	No	Yes	Don't Know	Refused	No	Yes	Don't Know	Refused
Disability (Unknown type)	No	Yes	Don't Know	Refused	___/___/___	No	Yes	Don't Know	Refused	No	Yes	Don't Know	Refused
Unknown Barriers	No	Yes	Don't Know	Refused	___/___/___	No	Yes	Don't Know	Refused	No	Yes	Don't Know	Refused
Learning Disability	No	Yes	Don't Know	Refused	___/___/___	No	Yes	Don't Know	Refused	No	Yes	Don't Know	Refused

Domestic Violence Assessment

~Assessment date: ___/___/___ ~Domestic violence experience: No Yes** Don't know Refused **If yes) When experience
 occurred: Past three months Three to six weeks ago Six to twelve months ago More than a year ago Don't know Refused
 ~Restriction: Restrict to Org Unrestricted

Financial Assessment

~Assessment date: ___/___/___ ~Income received: No Yes Don't Know Refused ~Non-cash benefits: No Yes Don't Know
 Refused

Source of Income	Receiving income?	Amount from Source	Source of Non-cash Benefit	Receiving income?	Amount from Source

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Earned Income (employment income)	No Yes	\$ _____.00	Food Stamps/Money for food on benefits card	No Yes	\$ _____.00
Full Time Employment	No Yes	\$ _____.00	MEDICAID	No Yes	\$ _____.00
Part Time Employment	No Yes	\$ _____.00	MEDICARE	No Yes	\$ _____.00
Seasonal Agricultural Worker	No Yes	\$ _____.00	ADATSA	No Yes	\$ _____.00
Unknown	No Yes	\$ _____.00	State Children's Health Insurance Program	No Yes	\$ _____.00
Unemployment Insurance	No Yes	\$ _____.00	WIC	No Yes	\$ _____.00
Supplemental Security Income	No Yes	\$ _____.00	Veteran's Administration Medical Services	No Yes	\$ _____.00
Veteran's Disability Payment	No Yes	\$ _____.00	TANF Child Care Services	No Yes	\$ _____.00
Private Disability Insurance	No Yes	\$ _____.00	TANF Transportation Services	No Yes	\$ _____.00
Worker's Compensation	No Yes	\$ _____.00	Other TANF-funded Services	No Yes	\$ _____.00
TANF	No Yes	\$ _____.00	Sec. 8, Public Housing/Other Rental Assistance	No Yes	\$ _____.00
General Assistance	No Yes	\$ _____.00	Other Source	No Yes	\$ _____.00
Retirement (Social Security)	No Yes	\$ _____.00			
Street Income	No Yes	\$ _____.00			
Veteran's Pension	No Yes	\$ _____.00			
Other Pension	No Yes	\$ _____.00			
Child Support	No Yes	\$ _____.00			
Alimony	No Yes	\$ _____.00			
Other Income	No Yes	\$ _____.00			
Monthly income from all sources	No Yes	\$ _____.00	Monthly income from all sources	No Yes	\$ _____.00

Employment Assessment (18 and over)

~Assessment date: __/__/____ ~Employed: Yes No Don't Know Refused ~Looking for work: Yes No Don't Know Refused
 ~Restriction : Restrict to Org Unrestricted

Adult Education Assessment (18 and over)

~Assessment date: __/__/____ ~Currently in school/working on degree: Yes No Don't Know Refused
 ~Received vocational training/apprenticeship: Yes No Don't Know Refused ~Highest grade completed: No School Completed
 Nursery School-4th Grade 5th-6th Grade 7th-8th Grade 9th Grade 10th Grade 11th Grade 12th Grade/No Diploma High School Diploma GED Post-
 Secondary School Don't Know Refused ~Secondary education: None Associates Degree Bachelors Masters Doctorate Some College
 Other Grad/Prof Degree Don't Know Refused ~Restriction : Restrict to Org Unrestricted

Child Education Assessment (If applicable – Under 18)

~Assessment date: __/__/____ ~Highest grade completed: No School Completed Nursery School-4th Grade 5th-6th Grade 7th-8th
 Grade 9th Grade 10th Grade 11th Grade 12th Grade/No Diploma High School Diploma GED Post-Secondary School Don't Know Refused
 ~Currently Enrolled Status: Yes No Don't know Refused ~Restriction : Restrict to Org Unrestricted

Veteran Assessment (18 and over)

~Assessment date: __/__/____ ~Veteran status: No Yes Don't Know Refused ~Military branch: Army Air Force Navy
 Marines Other Unknown Don't Know Refused ~Military service era: _____
 ~Discharge status: _____ ~Restriction : Restrict to Org Unrestricted

Health Assessment

~Assessment date: __/__/____ ~General health status: Excellent Very Good Good Fair Poor Don't Know Refused
 ~Restriction : Restrict to Org Unrestricted

PROGRAM ENROLLMENT

~Name: _____ ~Enrollment Date: __/__/____
 ~Case: _____ ~Program: _____
 ~Grant: _____ ~Family: _____
 ~Relationship to head of household: Self Parent Son Daughter Dependent Child Grandparent Guardian Spouse Other Family
 Member Other Non-Family Other Caretaker Grandchild Step Child Significant Other (Non-Married)
 ~Case manager: _____ ~Restriction : Restrict to Org Unrestricted

SERVICES

~Grant: _____
 ~Service: _____
 ~Location: _____ ~Date: __/__/____ ~Units of measure: Dollars Minutes Count Hours
 ~Unit value: \$ _____.00 ~Total: \$ _____.00
 ~User performing the service: _____
 ~Turn away reason: Did not comply with program rules Did not meet eligibility criteria Facility full Left before program completion Service not
 available
 ~Restriction : Restrict to Org Unrestricted
 ~Case Notes:

