KS BOS HMIS

CoC/ESG Intake Form for Project Types:

Emergency Shelter, Safe Haven, Street Outreach

SOCIAL SECURITY NUMBER (SSN)	☐☐☐-☐☐-☐☐☐☐
QUALITY OF SSN	☐ Full SSN reported ☐ Approximate/partial SSN reported ☐ Client doesn't know ☐ Client refused ☐ Data not collected
CLIENT NAME	
Last:	
First:	
Middle:	Suffix:
QUALITY OF NAME	☐ Full name reported ☐ Partial, street name, or code name reported ☐ Client doesn't know ☐ Client refused ☐ Data not collected
DATE OF BIRTH (DOB) (MM/DD/YYYY)	☐☐-☐☐-☐☐☐☐
QUALITY OF DOB	☐ Full DOB reported ☐ Approximate/partial DOB reported ☐ Client doesn't know ☐ Client refused ☐ Data not collected

GENDER

☐ Female
☐ Male
☐ Trans Female (MTF or Male to Female)
☐ Trans Male (FTM or Female to Male)
☐ Gender Non-Conforming (not exclusively male or female)
☐ Client doesn't know
☐ Client refused
☐ Data not collected

RACE

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander
☐ Asian
☐ Client doesn't know
☐ Client refused
☐ Data not collected

ETHNICITY

☐ Non-Hispanic/Non-Latino
☐ Hispanic/Latino
☐ Client doesn't know
☐ Client refused
☐ Data not collected

VETERAN STATUS

☐ Yes
☐ No
☐ Client doesn't know
☐ Client refused
☐ Data not collected

RELATIONSHIP TO HEAD OF HOUSEHOLD

☐ Self (head of household)
☐ Head of household's child
☐ Head of household's spouse or partner
☐ Head of household's other relation member
☐ Other: non-relation member

PROJECT NAME	
PROJECT START DATE (MM/DD/YYYY)	
DATE OF ENGAGEMENT ***Night by Night Emergency Shelters & Street Outreach Projects Only*** *(Leave blank if this has not happened)*	

PRIOR LIVING SITUATION *(Where did the client sleep the night before entering this project?) (PICK ONLY 1)*

HOMELESS SITUATION

- ☐ Place not meant for human habitation (vehicle, anywhere outside)
- ☐ Emergency shelter, including hotel or motel paid for w/ emergency shelter voucher or RHY-funded host home
- ☐ Safe Haven

INSTITUTIONAL SITUATION

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

TRANSITIONAL & PERMANENT HOUSING SITUATION

- ☐ Residential project or halfway house with no homeless criteria
- ☐ Hotel or motel paid for without emergency shelter voucher
- ☐ Transitional housing for homeless persons (including homeless youth)
- ☐ Host Home (non-crisis)
- ☐ Staying or living in a friend's room, apartment, or house
- ☐ Staying or living in a family member's room, apartment, or house
- ☐ Rental by client, with GPD TIP subsidy
- ☐ Rental by client, with VASH housing subsidy
- ☐ Permanent housing (other than RRH) for formerly homeless persons
- ☐ Rental by client, with RRH or equivalent subsidy
- ☐ Rental by client, with HCV voucher (tenant or project)
- ☐ Rental by client in a public housing unit
- ☐ Rental by client, no ongoing housing subsidy
- ☐ Rental by client, with other ongoing housing subsidy
- ☐ Owned by client, with ongoing housing subsidy
- ☐ Owned by client, no ongoing housing subsidy

- ☐ Client doesn't know
- ☐ Client refused
- ☐ Data not collected

LENGTH OF STAY IN PRIOR LIVING SITUATION *(How long did the client stay in that 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
- ☐ Data not collected

APPROXIMATE DATE HOMELESSNESS STARTED
*(for the client's **current** episode of homelessness)*

MONTH DAY YEAR

Number of times the client has been on the streets, in ES, or Safe Haven in the past three years including today *(Regardless of where they stayed last night)*

- ☐ One time
- ☐ Two times
- ☐ Three times
- ☐ Four or more times
- ☐ Client doesn't know
- ☐ Client refused
- ☐ Data not collected

Total number of months homeless on the streets, in ES, or SH in the past three years

- ☐ One month (first time)
- ☐ Two months
- ☐ Three months
- ☐ Four months
- ☐ Five months
- ☐ Six months
- ☐ Seven months
- ☐ Eight months
- ☐ Nine months
- ☐ Ten months
- ☐ Eleven months
- ☐ Twelve months
- ☐ More than 12 months
- ☐ Client doesn't know
- ☐ Client refused
- ☐ Data not collected

DISABLING CONDITION

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

PHYSICAL DISABILITY

☐ No
☐ Yes*

☐ Client doesn't know
☐ Client refused
☐ Data not collected

***If YES for Physical Disability**
Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

DEVELOPMENTAL DISABILITY

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

CHRONIC HEALTH CONDITION

☐ No
☐ Yes*

☐ Client doesn't know
☐ Client refused
☐ Data not collected

***If YES for Chronic Health Condition**
Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

HIV/AIDS

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

MENTAL HEALTH PROBLEM

☐ No
☐ Yes*

☐ Client doesn't know
☐ Client refused
☐ Data not collected

***If YES for Mental Health Problem**
Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

SUBSTANCE ABUSE PROBLEM

☐ No
☐ Alcohol abuse
☐ Drug abuse
☐ Both alcohol and drug abuse

☐ Client doesn't know
☐ Client refused
☐ Data not collected

***If YES for Substance Abuse Problem**
Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

DOMESTIC VIOLENCE VICTIM/SURVIVOR		
☐ No ☐ Yes*		☐ Client doesn't know ☐ Client refused ☐ Data not collected
***If YES to Domestic Violence Victim/Survivor**		
When did this experience occur?	☐ Within the past three months ☐ Three to six months ago (excluding six months exactly) ☐ From six to twelve months ago (excluding one year exactly) ☐ More than a year ago	☐ Client doesn't know ☐ Client refused ☐ Data not collected
Are you currently fleeing?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client refused ☐ Data not collected

CASH INCOME FOR INDIVIDUAL		
Income from Any Source?	☐ No ☐ Yes*	☐ Client doesn't know ☐ Client refused ☐ Data not collected

***If YES to Income from Any Source – Indicate all sources that apply**	
Income Source (Check all that apply)	**Monthly Amount**
☐ Earned Income	
☐ Unemployment Insurance	
☐ Supplemental Security Income (SSI)	
☐ Social Security Disability Insurance (SSDI)	
☐ VA Service-Connected Disability Compensation	
☐ VA Non-Service Connected Disability Compensation	
☐ Private Disability Insurance	
☐ Worker's Compensation	
☐ Temporary Assistance for Needy Families (TANF)	
☐ General Assistance (GA)	
☐ Retirement Income from Social Security	
☐ Pension or Retirement Income from a Former Job	
☐ Child Support	
☐ Alimony and Other Spousal Support	
☐ Other Cash Income (Specify: _____)	
Total Monthly Amount	

NON-CASH BENEFITS		
Receiving Non-Cash Benefits?	☐ No ☐ Yes*	☐ Client doesn't know ☐ Client refused ☐ Data not collected

***If YES to Receiving Non-Cash Benefits – Indicate all sources that apply**

☐ Supplemental Nutrition Assistance Program (SNAP)
☐ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
☐ TANF Childcare Services
☐ TANF Transportation Services
☐ Other TANF-Funded Services
☐ Other Non-Cash Benefit (Specify source:_____)

HEALTH INSURANCE		
Covered by Health Insurance?	☐ No ☐ Yes*	☐ Client doesn't know ☐ Client refused ☐ Data not collected

***If YES to Covered by Health Insurance – Indicate all sources that apply**

☐ Medicaid
☐ Medicare
☐ State Children's Health Insurance Program
☐ Veteran's Administration (VA) Medical Services
☐ Employer-Provided Health Insurance
☐ Health Insurance Obtained Through COBRA
☐ Private Pay Health Insurance
☐ State Health Insurance for Adults
☐ Indian Health Services Program
☐ Other Health Insurance (Specify source:_____)

CONTACT INFORMATION (Optional – entered on the **Contacts** tab)	
Phone number	
Email	

ADDRESS (Optional – entered on the **Locations** tab)			
Street			
City			
State		Zip Code	

Signature of applicant stating all information is true and correct

Date