

NorCal/DosRios

HMIS FEMA/COVID 19 Intake Form - Non-Congregate Shelters – Adult

1. Intake Summary					
Agency Case No:			Service Point Client No:		
Intake Date	Month	Day	Year	Intake Staff Name	
Case Manager			Staff Direct Phone Line		
Agency Name			Client Acknowledgement signed <input type="checkbox"/> Yes <input type="checkbox"/> No		
Program Name			Release of Information (ROI) Signed <input type="checkbox"/> Yes <input type="checkbox"/> No		
2. Household Information					
Household Type	<input type="checkbox"/> Couple (parent & friend) & child(ren)		<input type="checkbox"/> Foster Parent(s) with child(ren)		<input type="checkbox"/> Other
	<input type="checkbox"/> Couple with no child(ren)		<input type="checkbox"/> Grandparent(s) with child(ren)		<input type="checkbox"/> Single Adult
	<input type="checkbox"/> Extended family unit		<input type="checkbox"/> Male Single Parent		<input type="checkbox"/> Two Parents with child(ren)
	<input type="checkbox"/> Female Single Parent		<input type="checkbox"/> Non-custodial Caregiver(s) w/child(ren)		
3. Client Information					
First		Middle		Last	
Suffix		Email Address			
Alias			Last or Current Address		
Telephone			SSN		
SSN Data Quality			U.S. Military Veteran <i>(adults only)</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
Date of Birth			DOB Data Quality		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender male to female <input type="checkbox"/> Transgender female to male <input type="checkbox"/> Gender Non-conforming <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
DOB Data Quality			<input type="checkbox"/> Full Reported <input type="checkbox"/> Partial/Approx. Reported <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused		
Primary Race & Secondary Race			Pri Sec <input type="checkbox"/> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> <input type="checkbox"/> Asian <input type="checkbox"/> <input type="checkbox"/> Black or African-American <input type="checkbox"/> <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> <input type="checkbox"/> White <input type="checkbox"/> <input type="checkbox"/> Client doesn't know <input type="checkbox"/> <input type="checkbox"/> Client refused		Ethnicity <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
Relationship to Head of Household (HoH)			<input type="checkbox"/> Self (Head of Household) <input type="checkbox"/> Head of Household's child <input type="checkbox"/> Head of Household's spouse or partner <input type="checkbox"/> Head of Household's other relation member <input type="checkbox"/> Other (non-relation member)		
Zip Code of Last Permanent Address			Disabling Condition? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused		Client Location (CoC) & Current County of Service <input type="checkbox"/> CA-516 <input type="checkbox"/> CA-523 <input type="checkbox"/> Del Norte <input type="checkbox"/> Colusa <input type="checkbox"/> Lassen <input type="checkbox"/> Glenn <input type="checkbox"/> Modoc <input type="checkbox"/> Trinity <input type="checkbox"/> Plumas <input type="checkbox"/> Shasta <input type="checkbox"/> Sierra <input type="checkbox"/> Siskiyou
Zip Data Quality			<input type="checkbox"/> Full Reported <input type="checkbox"/> Partial/Approx. Reported <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused		
NOTES:					

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4. Homeless Determination

<p>Prior Living Situation</p> <p>Where did you spend last night? <i>(all adults & unaccompanied youth)</i></p>	<p>--HOMELESS SITUATION--</p> <p><input type="checkbox"/> Place not meant for human habitation (car, abandoned building, bus or train station, etc.)</p> <p><input type="checkbox"/> Emergency shelter (incl. hotel/motel or campground paid for w/ES voucher, or RHY-funded Host Home Shelter) (ES)</p> <p><input type="checkbox"/> Safe Haven (SH)</p> <p>--INSTITUTIONAL SITUATIONS--</p> <p><input type="checkbox"/> Foster care home or foster care group home</p> <p><input type="checkbox"/> Hospital or other residential non-psychiatric medical facility</p> <p><input type="checkbox"/> Jail, prison, or juvenile detention facility</p> <p><input type="checkbox"/> Long-term care facility or nursing home</p> <p><input type="checkbox"/> Psychiatric hospital or other psychiatric facility</p> <p><input type="checkbox"/> Substance abuse treatment facility/detox</p> <p>--TEMPORARY AND PERMANENT HOUSING SITUATIONS</p> <p><input type="checkbox"/> Residential project or halfway house w/no homeless criteria</p> <p><input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher</p> <p><input type="checkbox"/> Transitional housing for homeless persons (including homeless youth)*</p> <p><input type="checkbox"/> Host Home (non-crisis)</p> <p><input type="checkbox"/> Staying or living in a friend's room, apartment or house</p> <p><input type="checkbox"/> Staying or living in a family member's room, apartment or house</p> <p><input type="checkbox"/> Rental by client, with GPD TIP housing subsidy</p> <p><input type="checkbox"/> Rental by client, with VASH subsidy</p> <p><input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons</p> <p><input type="checkbox"/> Rental by client, with RRH or equivalent subsidy</p> <p><input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based)</p> <p><input type="checkbox"/> Rental by client in a public housing unit</p> <p><input type="checkbox"/> Rental by client, no ongoing housing subsidy</p> <p><input type="checkbox"/> Rental by client, with other ongoing housing subsidy</p> <p><input type="checkbox"/> Owned by client, with ongoing housing subsidy</p> <p><input type="checkbox"/> Owned by client, no ongoing housing subsidy</p> <p>--OTHER--</p> <p><input type="checkbox"/> Client doesn't know</p> <p><input type="checkbox"/> Client refused</p> <p><input type="checkbox"/> Data Not Collected</p>	<p>* If yes to Transitional/Permanent Housing:</p> <p>On the night before, did you stay on the streets, ES or SH?</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Length of stay in previous place</p>	<p><input type="checkbox"/> One night or less</p> <p><input type="checkbox"/> Two to six nights</p> <p><input type="checkbox"/> One week or more, but less than one month</p> <p><input type="checkbox"/> One month or more, but less than 90 days</p> <p><input type="checkbox"/> 90 days or more, but less than one year</p> <p><input type="checkbox"/> One year or longer</p> <p><input type="checkbox"/> Client doesn't know</p> <p><input type="checkbox"/> Client refused</p>	<p>Number of times client has been homeless (on the streets, in ES, or SH) in past three years including today</p> <p><input type="checkbox"/> 1 time</p> <p><input type="checkbox"/> 2 times</p> <p><input type="checkbox"/> 3 times</p> <p><input type="checkbox"/> Four or more times</p> <p><input type="checkbox"/> Client doesn't know</p> <p><input type="checkbox"/> Client refused</p>
<p>Approximate date homelessness started</p> <p>Month Day Year</p>	<p>Total number of months homeless on the street in the past three years</p> <p><input type="checkbox"/> 1 month (this time is the first month)</p> <p><input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6</p> <p><input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11</p> <p><input type="checkbox"/> 12 <input type="checkbox"/> More than 12 months</p> <p><input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused</p>	

5. Monthly Income

Income from any source: Yes No Client doesn't know Client refused

Source of Income:	Receiving Income Source	Amount Received	Additional Household Members	Notes
Alimony or Other Spousal Support	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$	
Child Support	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$	
Earned Income (wages)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$	
General Assistance (GA)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$	
Pension or retirement income from another job	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$	
Private Disability Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$	
Retirement Income from Social Security	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$	
SSDI	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$	
SSI	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$	
TANF (including CalWORKs)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$	

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Unemployment Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$	
VA Non-Service Connected Disability Pension	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$	
VA Service Connected Disability Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$	
Worker's Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$	

6. Non-Cash Benefits

Non-cash benefit from any source: Yes No Client doesn't know Client refused

Source of Non-cash benefit:	Receiving Benefit	Type Received	Additional Household Members	Notes
SNAP including CalFresh (Food Stamps)	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Special Supplemental Nutrition Program (WIC)	<input type="checkbox"/> Yes <input type="checkbox"/> No			
TANF Child Care Services	<input type="checkbox"/> Yes <input type="checkbox"/> No			
TANF Transportation Services	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Other TANF Funded Services (Sec.8/Public Housing/Rent Assist)	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Other Source	<input type="checkbox"/> Yes <input type="checkbox"/> No			

7. Health Insurance

Covered by Health Insurance: Yes No Client doesn't know Client refused

Health Insurance type:	Covered?	Start date	Insurance Notes
MEDICAID/MEDI-CAL	<input type="checkbox"/> Yes <input type="checkbox"/> No		
MEDICARE	<input type="checkbox"/> Yes <input type="checkbox"/> No		
State Children's Health Insurance Program	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Veteran's Administration (VA) Medical Services	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Employer – Provided Health Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Health Insurance obtained through COBRA	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Private Pay Health Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No		
State Health Insurance for Adults	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Indian Health Services Program	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No		

8. Disabilities

Disability Type:	Disability Determination	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	Start date	Disability Notes
Alcohol Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> No <input type="checkbox"/> Client refused		
Both Alcohol and Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> No <input type="checkbox"/> Client refused		
Chronic Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> No <input type="checkbox"/> Client refused		
Developmental	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> No <input type="checkbox"/> Client refused		
Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> No <input type="checkbox"/> Client refused		
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> No <input type="checkbox"/> Client refused		

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	<input type="checkbox"/> Client refused		
Mental Health Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> No <input type="checkbox"/> Client refused	
Physical	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> No <input type="checkbox"/> Client refused	

9. Domestic Violence Questions

Are you a Domestic Violence Victim/Survivor?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused		
IF YES – When did the Domestic Violence experience occur?	<input type="checkbox"/> Within past 3 months <input type="checkbox"/> 3-6 mo. Ago <input type="checkbox"/> 6-12 mo. Ago <input type="checkbox"/> More than a year ago <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused		
	IF YES – Are you currently fleeing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused		

10. Coordinated Entry Questions

Do you have a felony conviction?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Registered sex offender?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been denied housing because of criminal convictions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any pets?	<input type="checkbox"/> Yes <input type="checkbox"/> No

11. Residential Move-In Date (RRH Only)

If Yes, Date of Move-In	Month	Day	Year
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12. FEMA (NCS) COVID 19 – Additional Information for Head of Household

Last or current permanent address:			
Street Address	City		
State	Zip		
Address Data Quality	<input type="checkbox"/> Full Reported <input type="checkbox"/> Partial/Approx. Reported <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	Head of Household email address:	<input type="checkbox"/> Full Reported <input type="checkbox"/> Partial/Approx. Reported <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
Head of Household Cell Phone Number:	<input type="checkbox"/> Full Reported <input type="checkbox"/> Partial/Approx. Reported <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	COVID-19 Screening Results for qualifying Household member	<input type="checkbox"/> Asymptomatic Low Risk <input type="checkbox"/> Asymptomatic High Risk <input type="checkbox"/> COVID-19 Exposed <input type="checkbox"/> COVID-19 Positive
Total Number of Adults in Household (Numbers should reflect the total number of adults in the household who will need to be permanently housed at exit from the NCS project)		<input type="checkbox"/> 0 <input type="checkbox"/> 6 <input type="checkbox"/> 1 <input type="checkbox"/> 7 <input type="checkbox"/> 2 <input type="checkbox"/> 8 <input type="checkbox"/> 3 <input type="checkbox"/> 9 <input type="checkbox"/> 4 <input type="checkbox"/> 10 <input type="checkbox"/> 5	
Total Number of Children in Household (Numbers should reflect the total number of children in the household who will need to be permanently housed at exit from the NCS project)		<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10	

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Pets in Household	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected	Service animal in Household	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Access/functional needs identified	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected	Unit Type	<input type="checkbox"/> Hotel/Motel <input type="checkbox"/> Shelter <input type="checkbox"/> Apartment <input type="checkbox"/> Trailer
Name of Shelter		Address:	
		City: Zip:	

13. COVID-19 Assessment

Date Entered Into Social Isolation		Note on Exposure	
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Symptomatic

Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No

Test Results:

Positive Results Information

Medical Facility	
Quarantine Start Date:	
Quarantine End Date:	
Case Worker Name and Contact:	