



A Tradition of Stewardship
A Commitment to Service

Napa County Continuum of Care

HMIS Intake Form

PATH Project

Program Name: _____ Case Worker/Intake Person: _____ Date Client Started in your Program: _____

CLIENT PROFILE

First Name: _____ **Middle Name:** _____ **Last Name:** _____

Alias or Street Name: _____ **Emergency Contact:** _____

Social Security No. _____ Full SSN Partial SSN Client Doesn't Know Refused

Birth Date: _____ Full DOB Reported Partial DOB Client Doesn't Know Refused

If client is already in the system, skip to **Program Intake** section. If client is not in the system, answer the following questions.

Client Release of Information (ROI) Signed Consent on File Verbal Consent Client Refused Consent

Gender: Male Female Trans Female (MTF or Male to Female) Trans Male (FTM or Female to Male)
 Gender Non-Conforming (i.e. not exclusively male or female) Client Doesn't Know Refused Data not collected

Race: what best describes you? *Indicate clients' self-identification of one or more of five different racial categories.*

- American Indian or Alaskan Native Asian Black/African-American
- Native Hawaiian/Pacific Islander White Client Doesn't Know Refused

Ethnicity: Non-Hispanic/Non-Latino Hispanic Latino Client Doesn't Know Refused

Have you ever served in the US Military? (U.S. Military Veteran?) Yes No If yes, answer the following questions:

Year Entered Military Service: _____ **Separated Year:** _____

Theater of Operation:

- Afghanistan Iraq (Iraqi Freedom) Iraq (New Dawn) Persian Gulf War
- Korean War Vietnam War World War II Other Operations Client Doesn't Know Refused

Branch of Military: Army Air Force Navy Marines Coast Guard

Client Doesn't Know Refused Data not collected

Discharge Status: Honorable Bad Conduct Client Doesn't Know

General under honorable conditions Dishonorable Refused

General other than honorable conditions Uncharacterized Data not collected

PROGRAM INTAKE (Enrollment in Clarity/HMIS) QUESTIONS

SOAR

Connection with SOAR? Yes No

Living Situation – ANSWER ONLY ONE SECTION: A or B or C

Type of Residence/Living Situation prior to Program Start Date:

A - Homeless Living Situations

- Place not meant for habitation (e.g., Vehicle, river, camp, abandoned building, or anywhere outside).
- Emergency Shelter, including hotel or motel paid for with emergency shelter
- Safe Haven
- Interim Housing

Length of Stay in Homeless Living Situation?

- One night or less 2 to 6 nights 1 week or more, but less than one month

- 1 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 Refused Data not collected

Approximate date homelessness started? _____ REQUIRED

Number of times on the streets, in Emergency Shelter, or Safe Haven in the past 3 years?

- 0 (Not Homeless-Prevention Only) 1 (Homeless only this time) 2 3 4 or more
 Client Doesn't Know Refused Data not collected

Total number of months homeless on the street or in Emergency Shelter in the past 3 years?

- 1 month (this time is the first month) 8 months 11 months Client doesn't know
 2 months 4 months 6 months 9 months 12 months Client Refused
 3 months 5 months 7 months 10 months More than 12 months Data not collected

B - Institutional Living Situations

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

Length of Stay in Homeless Living Situation?

- One night or less 2 to 6 nights 1 week or more, but less than one month
 1 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 Refused Data not collected

Was length of stay less than 90 days? Yes** No* Client Doesn't Know Refused Data not collected

* If the answer is NO, you do not need to answer the below questions.

** If YES – On the night before, did client stay on the streets, Emergency Shelter or Safe Haven?

- Yes No Client Doesn't Know Refused Data not collected

Approximate date homelessness started? _____ REQUIRED

Number of times on the streets, in Emergency Shelter, or Safe Haven in the past 3 years?

- 0 (Not Homeless-Prevention Only) 1 (Homeless only this time) 2 3 4 or more
 Client Doesn't Know Refused Data not collected

Total number of months homeless on the street or in Emergency Shelter in the past 3 years?

Total number of months homeless on the street or in Emergency Shelter in the past 3 years?

- 1 month (this time is the first month) 8 months 11 months Client doesn't know
 2 months 4 months 6 months 9 months 12 months Client Refused
 3 months 5 months 7 months 10 months More than 12 months Data not collected

C – Transitional OR Permanent Housing Living Situations

- Hotel or motel paid for without emergency shelter voucher
 Owned by client – no housing subsidy
 Owned by client – with ongoing housing subsidy
 Permanent housing (other than Rapid Re-Housing) for formerly homeless persons
 Rental by client – No ongoing housing subsidy
 Rental by client – VASH housing subsidy (Veterans Affairs Supportive Housing)
 Rental by client with GPD TIP (Grant and Per Diem Transitional in Place)
 Rental by client – with other ongoing housing subsidy (including Rapid Re-Housing)
 Residential project or halfway house with no homeless criteria
 Staying or living in family member's room, apartment, or house
 Staying or living in friend's room, apartment, or house
 Transitional Housing for homeless persons (including homeless youth)

- Client doesn't know
- Client Refused
- Data not collected

Length of Stay in Homeless Living Situation?

- One night or less 2 to 6 nights 1 week or more, but less than one month
- 1 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 Refused Data not collected

Was length of stay less than 7 days? Yes** No* Client Doesn't Know Refused Data not collected

* If the answer is NO, you do not need to answer the below questions.

** If YES – On the night before, did client stay on the streets, Emergency Shelter or Safe Haven?

- Yes No Client Doesn't Know Refused Data not collected

Approximate date homelessness started? _____ REQUIRED

Number of times on the streets, in Emergency Shelter, or Safe Haven in the past 3 years?

- 0 (Not Homeless-Prevention Only) 1 (Homeless only this time) 2 3 4 or more
- Client Doesn't Know Refused Data not collected

Total number of months homeless on the street or in Emergency Shelter in the past 3 years?

Total number of months homeless on the street or in Emergency Shelter in the past 3 years?

- 1 month (this time is the first month) 8 months 11 months Client doesn't know
- 2 months 4 months 6 months 9 months 12 months Client Refused
- 3 months 5 months 7 months 10 months More than 12 months Data not collected

Complete PATH Engagement Date when the client has been engaged

Date of Engagement: _____

Complete Date of Status Determination when the enrollment status for the client has been determined

Date of Status Determination: _____

Client Became Enrolled in PATH? Yes No

If not enrolled in PATH, reason not enrolled: Client was found ineligible for PATH
 Client was not enrolled for other reasons

Disabling Conditions and Barriers - A disabling condition is one or more of the following:

If client answers yes to any disability then mark "Yes" on this question: Does client have a disabling condition? Yes No

Physical Disability Yes No Client Doesn't Know Refused Data not collected

If yes, will Physical Disability be Long Term? Yes No Client Doesn't Know Refused Data not collected

Developmental Disability Yes No Client Doesn't Know Refused Data not collected

If yes, does Developmental Disability substantially impair independence?

- Yes No Client Doesn't Know Refused Data not collected

Chronic Health Condition Yes No Client Doesn't Know Refused Data not collected

If yes, will Chronic Health be Long Term? Yes No Client Doesn't Know Refused Data not collected

HIV - AIDS Yes No Client Doesn't Know Refused Data not collected

If yes, does HIV-AIDS substantially impair independence?

- Yes No Client Doesn't Know Refused Data not collected

Mental Health Problem Yes No Client Doesn't Know Refused Data not collected

If yes, will Mental Health Disability be Long Term? Yes No Client Doesn't Know Refused Data not collected

Substance Abuse Problem No Alcohol Abuse Drug Abuse Both Alcohol and Drug Abuse

- Client Doesn't Know Refused Data not collected

Is Client a Domestic Violence Victim/Survivor? Yes No Client Doesn't Know Refused Data not collected
If yes, last occurrence? Within the past 3 months 3-6 months ago 6-12 months ago One year ago or more
 Client Doesn't Know Refused Data not collected
Is client currently fleeing? Yes No Client Doesn't Know Refused Data not collected

Cash Income for Individual

Income from Any Source? Yes No Client Doesn't Know Refused Data not collected

<input type="checkbox"/> Earned Income \$ _____	<input type="checkbox"/> Social Security Disability Income (SSDI) \$ _____
<input type="checkbox"/> Child Support \$ _____	<input type="checkbox"/> Social Security Income (SSI) \$ _____
<input type="checkbox"/> General Assistance \$ _____	<input type="checkbox"/> Spousal Support \$ _____
<input type="checkbox"/> TANF/CalWorks \$ _____	<input type="checkbox"/> Unemployment Insurance \$ _____
<input type="checkbox"/> Private Disability Insurance \$ _____	<input type="checkbox"/> VA Service-Connected Disability Compensation \$ _____
<input type="checkbox"/> Retirement from Social Security \$ _____	<input type="checkbox"/> VA Non-Service Connected Disability Compensation \$ _____
<input type="checkbox"/> Pension from a Former Job \$ _____	<input type="checkbox"/> Worker's Compensation \$ _____
<input type="checkbox"/> Other Income \$ _____ Source: _____	

Non-Cash Benefits

<input type="checkbox"/> CalFresh (Food Stamps/SNAP)	<input type="checkbox"/> TANF/CalWorks Transportation Services
<input type="checkbox"/> TANF/CalWorks Childcare Services	<input type="checkbox"/> Other TANF/CalWorks-Funded Services
<input type="checkbox"/> WIC (Supplemental Nutrition for Women, Infants, and Children)	<input type="checkbox"/> Other Non-Cash Benefits – Source: _____

Health Insurance

<input type="checkbox"/> Employer Provided	<input type="checkbox"/> Obtained through COBRA
<input type="checkbox"/> Healthy Kids (CHI) (State Children's HIP)	<input type="checkbox"/> Private Pay Health Insurance
<input type="checkbox"/> Indian Health Services Program	<input type="checkbox"/> State Health Insurance for Adults
<input type="checkbox"/> Medical/Medicaid	<input type="checkbox"/> Veteran Administration (VA) Medical Services
<input type="checkbox"/> Medicare	<input type="checkbox"/> Other: Specify _____

SERVICES Provided – PATH Funded

<input type="checkbox"/> Reengagement	Date of Service: _____	<input type="checkbox"/> Residential Supportive Services	Date of Service: _____
<input type="checkbox"/> Screening	Date of Service: _____	<input type="checkbox"/> Housing Minor Renovation	Date of Service: _____
<input type="checkbox"/> Clinical Assessment	Date of Service: _____	<input type="checkbox"/> Housing Moving Assistance	Date of Service: _____
<input type="checkbox"/> Habilitation/Rehabilitation	Date of Service: _____	<input type="checkbox"/> Housing Eligibility Determination	Date of Service: _____
<input type="checkbox"/> Community Mental Health	Date of Service: _____	<input type="checkbox"/> Security Deposit	Date of Service: _____
<input type="checkbox"/> Substance Use Treatment	Date of Service: _____	<input type="checkbox"/> One-Time Rent for Eviction Prevention	Date of Service: _____
<input type="checkbox"/> Case Management	Date of Service: _____	<input type="checkbox"/> Other PATH Funded Service	Date of Service: _____

REFERRALS Provided – PATH

<input type="checkbox"/> Community Mental Health	Date of Referral: _____	<input type="checkbox"/> Attained	<input type="checkbox"/> Not Attained	<input type="checkbox"/> Unknown
<input type="checkbox"/> Substance Use Treatment	Date of Referral: _____	<input type="checkbox"/> Attained	<input type="checkbox"/> Not Attained	<input type="checkbox"/> Unknown
<input type="checkbox"/> Primary Health/Dental Care	Date of Referral: _____	<input type="checkbox"/> Attained	<input type="checkbox"/> Not Attained	<input type="checkbox"/> Unknown
<input type="checkbox"/> Job Training	Date of Referral: _____	<input type="checkbox"/> Attained	<input type="checkbox"/> Not Attained	<input type="checkbox"/> Unknown
<input type="checkbox"/> Educational Services	Date of Referral: _____	<input type="checkbox"/> Attained	<input type="checkbox"/> Not Attained	<input type="checkbox"/> Unknown
<input type="checkbox"/> Housing Services	Date of Referral: _____	<input type="checkbox"/> Attained	<input type="checkbox"/> Not Attained	<input type="checkbox"/> Unknown
<input type="checkbox"/> Temporary Housing	Date of Referral: _____	<input type="checkbox"/> Attained	<input type="checkbox"/> Not Attained	<input type="checkbox"/> Unknown
<input type="checkbox"/> Permanent Housing	Date of Referral: _____	<input type="checkbox"/> Attained	<input checked="" type="checkbox"/> Not Attained	<input type="checkbox"/> Unknown
<input type="checkbox"/> Income Assistance	Date of Referral: _____	<input type="checkbox"/> Attained	<input type="checkbox"/> Not Attained	<input type="checkbox"/> Unknown
<input type="checkbox"/> Employment Assistance	Date of Referral: _____	<input type="checkbox"/> Attained	<input type="checkbox"/> Not Attained	<input type="checkbox"/> Unknown
<input type="checkbox"/> Medical Insurance	Date of Referral: _____	<input type="checkbox"/> Attained	<input type="checkbox"/> Not Attained	<input type="checkbox"/> Unknown