



# HMIS ESG Program Intake Form

Community Alliance for the Homeless | HMIS | Memphis, TN 38103 | Phone: 901.527.1302

FOR TEXT FIELDS, USE BLOCK LETTERS. OTHERWISE, MARK APPROPRIATE BOXES WITH AN "X". Complete a separate form for each member of the household

Enrollment COVID-19 related?  No  Yes

**SOCIAL SECURITY NUMBER: [All clients]**

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**QUALITY OF SOCIAL SECURITY [All clients]**

<input type="checkbox"/>	Full SSN reported	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Approximate or partial SSN reported	<input type="checkbox"/>	Data not collected
<input type="checkbox"/>	Client doesn't know		

<b>Last Name:</b>																				
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<b>First Name</b>																				
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**QUALITY OF CURRENT NAME [All clients]**

<input type="checkbox"/>	Full name reported	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Partial name reported	<input type="checkbox"/>	Data not collected
<input type="checkbox"/>	Client doesn't know		

**QUALITY OF DATE OF BIRTH [All clients]**

<input type="checkbox"/>	Full DOB reported	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Approximate or partial DOB reported	<input type="checkbox"/>	Data not collected
<input type="checkbox"/>	Client doesn't know		

**DATE OF BIRTH: (e.g., 10/23/1978) [All clients]**

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Month                      Day                      Year

<b>Middle Name:</b>																				
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**GENDER [All clients]**

<input type="checkbox"/>	Female	<input type="checkbox"/>	Gender Non-Conforming (i.e., not exclusively male or female)
<input type="checkbox"/>	Male	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Trans Female (MTF or Male to Female)	<input type="checkbox"/>	Client refused

<input type="checkbox"/>	Trans Male (FTM or Female to Male)	<input type="checkbox"/>	Data Not Collected
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**RACE** (Select all applicable) [All clients]

<input type="checkbox"/>	American Indian or Alaskan Native	<input type="checkbox"/>	White
<input type="checkbox"/>	Asian	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Black or African American	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Native Hawaiian or Other Pacific Islander	<input type="checkbox"/>	Data not collected

**ETHNICITY** [All clients]

<input type="checkbox"/>	Non-Hispanic / Non-Latino	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Hispanic / Non-Latino	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Data not collected		

**VETERANS STATUS** [All clients]

<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Yes	<input type="checkbox"/>	Data not collected
<input type="checkbox"/>	Client doesn't know		

**IF "YES" TO VETERAN STATUS**

Year entered Military Service: \_\_\_\_\_

Year separated from Military Service: \_\_\_\_\_

THEATRE OF OPERATIONS	NO	YES	Client doesn't know	Client refused	Data not collected
Theater of Operations: World War II	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Theater of Operations: Korean War	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Theater of Operations: Vietnam War	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Theater of Operations: Persian Gulf War (Desert Storm)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Theater of Operations: Afghanistan (Operation Enduring Freedom)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Theater of Operations: Iraq (Operation Iraqi Freedom)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Theater of Operations: Iraq (Operation New Dawn)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Theater of Operations: Other peacekeeping operations or military interventions (such as Lebanon, Panama, Somalia, Bosnia, Kosovo)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**BRANCH (es) OF THE MILITARY**

<input type="checkbox"/>	Army	<input type="checkbox"/>	Coast Guard
<input type="checkbox"/>	Air Force	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Navy	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Marines	<input type="checkbox"/>	Data not collected

**DISCHARGE STATUS**

<input type="checkbox"/>	Honorable	<input type="checkbox"/>	Uncharacterized
<input type="checkbox"/>	General under honorable conditions	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Other than honorable conditions (OTH)	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Bad Conduct	<input type="checkbox"/>	Data not collected
<input type="checkbox"/>	Dishonorable		

**PROGRAM ENROLLMENT**

**PROGRAM START DATE**

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Month                      Day                      Year

Is the Client an Adult or Head of Household?

Yes is Auto Generated for these questions

Is the Program Type Either Emergency Shelter, Safe Haven, or Street Outreach? Yes is Auto Generated for these questions

**LIVING SITUATION**

<input type="checkbox"/>	Emergency shelter, including hotel/motel paid for w/voucher	<input type="checkbox"/>	Rental by client, with GPD TIP subsidy
<input type="checkbox"/>	Foster care home or foster care group home	<input type="checkbox"/>	Rental by client, with VASH subsidy
<input type="checkbox"/>	Hospital or other residential non-psychiatric medical facility	<input type="checkbox"/>	Rental by client, with other ongoing housing subsidy
<input type="checkbox"/>	Hotel or motel paid for without emergency shelter voucher	<input type="checkbox"/>	Residential project or halfway house with no homeless criteria
<input type="checkbox"/>	Interim Housing	<input type="checkbox"/>	Safe Haven
<input type="checkbox"/>	Rental by client, no ongoing housing subsidy	<input type="checkbox"/>	Staying or living in a family member's room, apartment or house
<input type="checkbox"/>	Jail, prison or juvenile detention facility	<input type="checkbox"/>	Staying or living in a friend's room, apartment or house
<input type="checkbox"/>	Long-term care facility or nursing home	<input type="checkbox"/>	Substance abuse treatment facility or detox center
<input type="checkbox"/>	Owned by client, no ongoing housing subsidy	<input type="checkbox"/>	Transitional housing for homeless persons (including homeless youth)
<input type="checkbox"/>	Owned by client, with ongoing housing subsidy	<input type="checkbox"/>	Client doesn't know

<input type="checkbox"/>	Permanent housing (other than RRH) for formerly homeless persons	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Place not meant for habitation	<input type="checkbox"/>	Data not collected
	Psychiatric hospital or other psychiatric facility		

**LENGTH OF STAY IN PRIOR LIVING SITUATION**

<input type="checkbox"/>	One night or less	<input type="checkbox"/>	Two nights to six nights	<input type="checkbox"/>	One week or more, but less than one month
<input type="checkbox"/>	1 than 90 days month or more, but less	<input type="checkbox"/>	90 days or more, but less than a year	<input type="checkbox"/>	A year or longer
<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected

**APPROXIMATE DATE HOMELESSNESS STARTED:**

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Month                      Day                      Year

**NUMBER OF TIMES ON THE STREETS**

<input type="checkbox"/>	One time	<input type="checkbox"/>	Two time	<input type="checkbox"/>	Three times
<input type="checkbox"/>	Four or More times	<input type="checkbox"/>	1 month or more, but less than 90 days	<input type="checkbox"/>	90 days or more, but less than a year
<input type="checkbox"/>	A year or longer	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused
				<input type="checkbox"/>	Data not collected

**TOTAL NUMBER OF MONTHS HOMELESS ON THE STREET, IN ES, OR SH IN THE PAST THREE YEARS:**

<input type="checkbox"/>	One month (this is the first time)	<input type="checkbox"/>	2 months	<input type="checkbox"/>	3 months	<input type="checkbox"/>	4 months
<input type="checkbox"/>	5 months	<input type="checkbox"/>	6 months	<input type="checkbox"/>	7 months	<input type="checkbox"/>	8 months
<input type="checkbox"/>	9 months	<input type="checkbox"/>	10 months	<input type="checkbox"/>	11 months	<input type="checkbox"/>	12 months
<input type="checkbox"/>	More than 12 months	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected

**DISABLING CONDITION AND BARRIERS**

**Disabling Condition**

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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If yes,

**Physical Disability**

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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Long Term?

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<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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**Developmental Disability**

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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**Substantially Impairs Independence**

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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**Chronic Health Condition**

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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**Long Term?**

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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**HIV – AIDS**

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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**Substantially Impairs Independence?**

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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**Mental Health Problem**

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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**Long Term?**

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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**Substance Abuse Problem**

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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If yes, please check below:

<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	Both Alcohol & Drug Abuse
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**Long Term?**

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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**Domestic Violence Victim/Survivor**

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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If yes, last occurrence (please check one):

<input type="checkbox"/>	Within the past three months?	<input type="checkbox"/>	Three to six months, excluding six months exactly	<input type="checkbox"/>	Six months to one year, excluding one year exactly
<input type="checkbox"/>	One year or More	<input type="checkbox"/>	Client Doesn't Know	<input type="checkbox"/>	Client Refused
<input type="checkbox"/>	Data Not Collected				

Are you currently fleeing?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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**INCOME FROM ANY SOURCE**

Have you received income from any source?

<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Yes	<input type="checkbox"/>	Data not collected
<input type="checkbox"/>	Client doesn't know		

If yes to income from any source, please check source(s):

No	Yes	Source of Income	Amount	No	Yes	Source of Income	Amount
<input type="checkbox"/>	<input type="checkbox"/>	Unemployment Insurance	\$	<input type="checkbox"/>	<input type="checkbox"/>	VA Non-Service Connected Disability Pension	\$
<input type="checkbox"/>	<input type="checkbox"/>	Worker's Compensation	\$	<input type="checkbox"/>	<input type="checkbox"/>	Pension or Retirement Income from a former Job	\$
<input type="checkbox"/>	<input type="checkbox"/>	Private Disability Insurance	\$	<input type="checkbox"/>	<input type="checkbox"/>	Temporary Assistance for Needy Families (TANF)	\$
<input type="checkbox"/>	<input type="checkbox"/>	VA Service-Connected Disability Compensation	\$	<input type="checkbox"/>	<input type="checkbox"/>	General Assistance (GA)	\$
<input type="checkbox"/>	<input type="checkbox"/>	Social Security Disability Insurance (SSDI)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Alimony and Other Spousal Support	\$
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Security Income (SSI)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Child Support	\$
<input type="checkbox"/>	<input type="checkbox"/>	Retirement Income from Social Security	\$	<input type="checkbox"/>	<input type="checkbox"/>	Other Cash Income*	\$

Source of Other Cash Income:

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**NON-CASH BENEFITS**

Have you received non-cash benefits from any source?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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If yes to Non-Cash benefits, please check source(s)

<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Nutrition Assistance Program (SNAP) (Previously known as Food Stamps)	<input type="checkbox"/>	<input type="checkbox"/>	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
<input type="checkbox"/>	<input type="checkbox"/>	SANF Child Care services (or use local name)	<input type="checkbox"/>	<input type="checkbox"/>	Temporary Assistance for Needy Families (TANF)
<input type="checkbox"/>	<input type="checkbox"/>	TANF transportation services (or use local name)	<input type="checkbox"/>	<input type="checkbox"/>	Other TANF funded Services (or use local name)
<input type="checkbox"/>	<input type="checkbox"/>	Section 8, public housing, or other ongoing rental assistance	<input type="checkbox"/>	<input type="checkbox"/>	Temporary rental assistance
<input type="checkbox"/>	<input type="checkbox"/>	Other Source	If yes to "Other" Source, please specify:		

### HEALTH INSURANCE INFORMATION

Covered by health insurance?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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If yes, please check.

NO	YES	Health Insurance Providers	NO	YES	Health Insurance Providers
<input type="checkbox"/>	<input type="checkbox"/>	MEDICAID	<input type="checkbox"/>	<input type="checkbox"/>	Health Insurance obtained through COBRA
<input type="checkbox"/>	<input type="checkbox"/>	MEDICARE	<input type="checkbox"/>	<input type="checkbox"/>	Private Pay Health Insurance
<input type="checkbox"/>	<input type="checkbox"/>	State Children's Health Insurance Program (or use local name)	<input type="checkbox"/>	<input type="checkbox"/>	State Health Insurance for Adults (or use local name)
<input type="checkbox"/>	<input type="checkbox"/>	Veteran's Administration (VA) Medical Services	<input type="checkbox"/>	<input type="checkbox"/>	Indian Health Services Program
<input type="checkbox"/>	<input type="checkbox"/>	Employer – Provided Health Insurance	<input type="checkbox"/>	<input type="checkbox"/>	Other (please specify)