

Identification (All fields required unless otherwise noted)

HMIS consent? No (refused) Signed Consent Form

First Name: _____ Middle Name (Optional): _____

Last Name: _____ Suffix (Optional): _____

Name Data Quality:	Physical Description (Optional):	Last Known Permanent Address:						
Did the client provide their full name?		Where have you last lived for 90 days or more? (Not including emergency shelters and transitional housing)						
<input type="checkbox"/> Full Name Reported <input type="checkbox"/> Partial, street name, or code name reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected		Address: _____ City: _____ County: _____ State: _____ Zip: _____						
Date of Birth:	SSN:							
____/____/____ <input type="checkbox"/> Full DOB reported <input type="checkbox"/> Approximate or partial DOB reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	____-____-____ <input type="checkbox"/> Full SSN reported <input type="checkbox"/> Approximate or partial SSN reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	Address Data Quality: <table border="0"> <tr> <td><input type="checkbox"/> Full address reported</td> <td><input type="checkbox"/> Client Doesn't Know</td> </tr> <tr> <td><input type="checkbox"/> Incomplete or estimated address reported</td> <td><input type="checkbox"/> Client Refused</td> </tr> <tr> <td><input type="checkbox"/> Data not Collected</td> <td><input type="checkbox"/> Data not Collected</td> </tr> </table>	<input type="checkbox"/> Full address reported	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Incomplete or estimated address reported	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data not Collected	<input type="checkbox"/> Data not Collected
<input type="checkbox"/> Full address reported	<input type="checkbox"/> Client Doesn't Know							
<input type="checkbox"/> Incomplete or estimated address reported	<input type="checkbox"/> Client Refused							
<input type="checkbox"/> Data not Collected	<input type="checkbox"/> Data not Collected							

Contact Information (Optional)

Phone Number	Phone Type	Contact Preference
Main: (____)____-____x____ <input type="checkbox"/> Leave message	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Message Center	<input type="checkbox"/> Phone <input type="checkbox"/> Alternate Phone <input type="checkbox"/> Text <input type="checkbox"/> Email
Alternate: (____)____-____x____ <input type="checkbox"/> Leave message	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Message Center	
Email	_____@_____	Notes

Demographics (All fields required unless otherwise noted)

Housing Status:	Family Type:
<input type="checkbox"/> Category 1 - Homeless <input type="checkbox"/> Category 2 - At Imminent Risk of Losing Housing (within 14 days or less) <input type="checkbox"/> Category 3 - Homeless only under other Federal Statutes <input type="checkbox"/> Category 4 - Fleeing Domestic Violence <input type="checkbox"/> At Risk of Homelessness <input type="checkbox"/> Stably Housed	<input type="checkbox"/> Unaccompanied <input type="checkbox"/> Single Parent <input type="checkbox"/> Two Parents <input type="checkbox"/> Adults No children
<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	

Relation (to Head of Household)	Gender:
<input type="checkbox"/> Self <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	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Doesn't identify as male, female, or transgender <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected

Disabled? (Physical, Developmental, Mental Health, Chronic Health Condition, HIV/AIDS, and/or Substance Use Disorder.)	Veteran (Have you ever served in the U.S. Military?)	Education Level (What is the highest level of education you've completed?)
<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	<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	<input type="checkbox"/> Less than Grade 5 <input type="checkbox"/> Grades 5-6 <input type="checkbox"/> Grades 7-8 <input type="checkbox"/> Grades 9-11 <input type="checkbox"/> Grade 12 / High school Diploma <input type="checkbox"/> GED <input type="checkbox"/> School program does not have grade levels <input type="checkbox"/> Some College <input type="checkbox"/> Associates degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Graduate degree <input type="checkbox"/> Vocational Certification <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not collected

Ethnicity	Race (check all that apply)
<input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	<input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> White <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected

Income and Insurance (All fields required unless otherwise noted)

Income Source (Check all that apply)	Stated Income	Pay Interval					
		Weekly	Every Other Week	Twice A Month	Monthly	Quarterly	Yearly
<input type="checkbox"/> No financial resources							
<input type="checkbox"/> Earned Income (<i>employment wages / cash</i>)	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Unemployment Insurance	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Supplemental Security Income (SSI)	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Social Security Disability Income (SSDI)	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> VA Service-Connected Disability Compensation	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> VA Non-Service-Connected Disability Pension	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Private Disability Insurance	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Workers Compensation	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Temporary Assistance for Needy Families (<i>CaWORKs</i>)	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> General Assistance (GA) (<i>General Relief (GR)</i>)	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Retirement Income from Social Security	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pension or retirement income from a former job	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Child Support	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Alimony or other spousal support	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other Source (Specify: _____)	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Client Doesn't Know							
<input type="checkbox"/> Client Refused							

Data not Collected

Income Documentation (Optional):	Comments (Optional):
<input type="checkbox"/> GR Form	
<input type="checkbox"/> CalWORKS Forms	
<input type="checkbox"/> Pension Letter/Stub	
<input type="checkbox"/> Pay Stub	
<input type="checkbox"/> Unemployment Insurance Forms	
<input type="checkbox"/> Unemployment Forms	
<input type="checkbox"/> Utility Allowance	
<input type="checkbox"/> W-2 Forms	
<input type="checkbox"/> Self Declaration	
<input type="checkbox"/> Child Support Forms	
<input type="checkbox"/> SSDI Form	
<input type="checkbox"/> Employer Printout/Letter	
<input type="checkbox"/> Social Security Forms	
<input type="checkbox"/> Workmans Comp	
<input type="checkbox"/> VA Documentation	
<input type="checkbox"/> SSI Forms	
<input type="checkbox"/> Self Employment Docs	

Non-Cash Benefits (Check all that apply):			
<input type="checkbox"/> None	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data not Collected
<input type="checkbox"/> Food Stamps (CalFresh) Amount: _____	<input type="checkbox"/> CalWorks Child Care	<input type="checkbox"/> Temporary Rental Assistance	
<input type="checkbox"/> WIC	<input type="checkbox"/> CalWorks Transportation	<input type="checkbox"/> Section 8 or Rental Assistance	<input type="checkbox"/> Medically Needy Amount: _____
	<input type="checkbox"/> Other CalWorks-Funded Services	<input type="checkbox"/> Other _____	

Health Insurance (Check all that apply):			
<input type="checkbox"/> No Health Insurance	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data not Collected
<input type="checkbox"/> MediCal	<input type="checkbox"/> MEDICARE	<input type="checkbox"/> State Children's Health Ins.	<input type="checkbox"/> VA Medical Services
<input type="checkbox"/> Employer Provided Health Ins.	<input type="checkbox"/> COBRA Health Ins.	<input type="checkbox"/> Private Health Ins.	<input type="checkbox"/> Indian Health Services Program
<input type="checkbox"/> Other _____			

Client Note (Optional)

Client Note:	
Type: <input type="checkbox"/> Information <input type="checkbox"/> Alert	
Private Customer: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Note Date: ___/___/___	

Emergency Contact Information (Optional)

Contact Type	Phone Number	Phone Type	Email
Alternate Contact <i>(Who is the best person to get in touch with you?)</i> Relationship: _____ First Name: _____ Last Name: _____	() ___ - ___ x _____	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Message Center	
Emergency <i>(In case of an emergency, who should we alert?)</i> <input type="checkbox"/> Same as above Relationship: _____ First Name: _____ Last Name: _____	() ___ - ___ x _____	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Message Center	

Program Entry (All fields required unless otherwise noted)

Program Name: _____

Program Entry Date: ____/____/____

Case Manager: _____

Living Situation Questions for Street Outreach, Emergency Shelter, or Safe Haven Projects

1. Type of Residence	
HOMELESS SITUATION	
<input type="checkbox"/> Place not meant for human habitation	<input type="checkbox"/> Owned by client, with ongoing housing subsidy
<input type="checkbox"/> Emergency shelter	<input type="checkbox"/> Permanent housing for formerly homeless persons
<input type="checkbox"/> Safe Haven	<input type="checkbox"/> Rental by client, no ongoing housing subsidy
<input type="checkbox"/> Interim Housing	<input type="checkbox"/> Rental by client, with VASH housing subsidy
INSTITUTIONAL SITUATION	<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 other (non-VASH) ongoing housing subsidy
<input type="checkbox"/> Hospital or other residential non-psychiatric medical facility	<input type="checkbox"/> Residential project or halfway house with no homeless criteria
<input type="checkbox"/> Jail, prison or juvenile detention facility	<input type="checkbox"/> Staying or living in a family member's room, apartment, or house
<input type="checkbox"/> Long-term care facility or nursing home	<input type="checkbox"/> Staying or living in a friend's room, apartment or house
<input type="checkbox"/> Psychiatric hospital or other psychiatric facility	<input type="checkbox"/> Transitional housing for homeless persons
<input type="checkbox"/> Substance abuse treatment facility or detox center	<input type="checkbox"/> Other
TRANSITIONAL & PERMANENT HOUSING SITUATION	<input type="checkbox"/> Client Doesn't Know
<input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher	<input type="checkbox"/> Client Refused
<input type="checkbox"/> Owned by client, no ongoing housing subsidy	<input type="checkbox"/> Data not Collected

2. Length of Stay in Prior Living Situation		
<input type="checkbox"/> One night or less	<input type="checkbox"/> One month or more, but less than 90 days	<input type="checkbox"/> Client Doesn't Know
<input type="checkbox"/> Two to six nights	<input type="checkbox"/> 90 days or more, but less than one year	<input type="checkbox"/> Client Refused
<input type="checkbox"/> One week or more, but less than one month	<input type="checkbox"/> One year or longer	<input type="checkbox"/> Data not Collected

Proceed to Question 5 ->

Living Situation Questions for All Project Types excluding Street Outreach, Emergency Shelter, or Safe Haven Projects

1. Type of residence

HOMELESS SITUATION

- Place not meant for human habitation
- Emergency Shelter
- Safe Haven
- Interim Housing

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

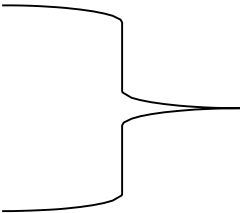
- Hotel or motel paid for without emergency shelter voucher
- Owned by client, no ongoing housing subsidy
- Owned by client, with ongoing housing subsidy
- Permanent housing for formerly homeless persons
- Rental by client, no ongoing housing subsidy
- Rental by client, with VASH housing subsidy
- Rental by client, with GPD TIP subsidy
- Rental by client, with other (non-VASH) ongoing housing subsidy
- Residential project or halfway house with no homeless criteria
- Staying or living in a family member's room, apartment, or house
- Staying or living in a friend's room, apartment, or house
- Transitional housing for homeless persons
- Client Doesn't Know
- Client Refused
- Data not Collected

3. Length of stay in prior living 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

- 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

- 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



2a. Did you stay less than 90 days?

- No
- Yes

2b. Did you stay less than 7 nights?

- No
- Yes

Proceed to Question 5

Proceed to Question 4

Proceed to Question 8

Proceed to Question 4

Proceed to Question 8

4. On the night before your current housing situation, did you stay on the streets, ES, or SH?
 No Yes

5. Approximate date started
 _____ / _____ / _____

6. Number of times the client has been on the streets, in ES, or SH in the past three years including today.
 Never in three years Three times Client Doesn't Know
 One time Four or more times Client Refused
 Two times Data not Collected

7. Total number of months homeless on the streets, in ES, or SH in the past three years.
 One month (this time is the first month) 7 12
 2 8 More than 12 months
 3 9 Client Doesn't Know
 4 10 Client Refused
 5 11 Data not Collected
 6

HOMELINESS - Adults aged 18 and older and Head of Household < 18 years old, required questions are shaded

Question	Check One Answer	Comments
8. What city were you residing in immediately prior to entry into this project?	<input type="checkbox"/> Aliso Viejo <input type="checkbox"/> Irvine <input type="checkbox"/> San Clemente <input type="checkbox"/> Anaheim <input type="checkbox"/> La Habra <input type="checkbox"/> San Juan <input type="checkbox"/> Atwood <input type="checkbox"/> La Palma Capistrano <input type="checkbox"/> Balboa <input type="checkbox"/> Laguna Beach <input type="checkbox"/> Santa Ana <input type="checkbox"/> Brea <input type="checkbox"/> Laguna Hills <input type="checkbox"/> Seal Beach <input type="checkbox"/> Buena Park <input type="checkbox"/> Laguna Niguel <input type="checkbox"/> Stanton <input type="checkbox"/> Capistrano Beach <input type="checkbox"/> Laguna Woods <input type="checkbox"/> Sunset Beach <input type="checkbox"/> Corona del Mar <input type="checkbox"/> Lake Forest <input type="checkbox"/> Tustin <input type="checkbox"/> Costa Mesa <input type="checkbox"/> Las Flores <input type="checkbox"/> Villa Park <input type="checkbox"/> Coto de Caza <input type="checkbox"/> Lemon Heights <input type="checkbox"/> Westminster <input type="checkbox"/> Cypress <input type="checkbox"/> Los Alamitos <input type="checkbox"/> Yorba Linda <input type="checkbox"/> Dana Point <input type="checkbox"/> Midway City <input type="checkbox"/> Outside Orange <input type="checkbox"/> El Modena <input type="checkbox"/> Mission Viejo County <input type="checkbox"/> Fountain Valley <input type="checkbox"/> Newport Beach <input type="checkbox"/> Client Doesn't <input type="checkbox"/> Fullerton <input type="checkbox"/> Orange Know <input type="checkbox"/> Garden Grove <input type="checkbox"/> Placentia <input type="checkbox"/> Client Refused <input type="checkbox"/> Huntington Beach <input type="checkbox"/> Rancho Santa <input type="checkbox"/> Data not Collected <input type="checkbox"/> Margarita	

WELLNESS - All clients, required questions are shaded

Question	Check One Answer	Comments
9. Have you been diagnosed with AIDS or have you tested positive for HIV?	<input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Yes** <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	

9a. Do you expect this to substantially impair your ability to live independently? (Required if question 9 is 'Yes')	<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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<p>9b. Do you have documentation of the disability and severity on file? (Required if question 9 is 'Yes')</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<p>9c. Are you currently receiving services or treatment for this condition? (Required if question 9 is 'Yes')</p>	<input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
<p>10. Do you have a chronic health condition?</p>	<input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Yes** <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
<p>10a. Do you expect this to be of long-continued and indefinite duration AND substantially impair your ability to live independently? (Required if question 10 is 'Yes')</p>	<input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
<p>10b. Do you have documentation of the disability and severity on file? (Required if question 10 is 'Yes')</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<p>10c. Are you currently receiving services or treatment for this condition? (Required if question 10 is 'Yes')</p>	<input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
<p>11. Do you have a physical disability?</p>	<input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Yes** <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
<p>11a. Do you expect this to be of long-continued and indefinite duration AND substantially impair your ability to live independently? (Required if question 11 is 'Yes')</p>	<input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
<p>11b. Do you have documentation of the disability and severity on file? (Required if question 11 is 'Yes')</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<p>11c. Are you currently receiving services or treatment for this condition? (Required if question 11 is 'Yes')</p>	<input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
<p>12. Do you <i>currently</i> have a drug or alcohol problem?</p>	<input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Alcohol** <input type="checkbox"/> Client Refused <input type="checkbox"/> Drug** <input type="checkbox"/> Data not Collected <input type="checkbox"/> Both**	
<p>12a. Do you expect this to be of long-continued and indefinite duration AND substantially impair your ability to live independently? (Required if question 12 is 'Alcohol', 'Drug', or 'Both')</p>	<input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
<p>12b. Do you have documentation of the disability and severity on file? (Required if question 12 is 'Alcohol', 'Drug', or 'Both')</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<p>12c. Are you currently receiving services or treatment for this condition? (Required if question 12 is 'Alcohol', 'Drug', or 'Both')</p>	<input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
<p>13. Have you ever been told you have a learning disability or developmental disability?</p>	<input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Yes** <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	

13a. Do you expect this to be of long–continued and indefinite duration AND substantially impair your ability to live independently? (Required if question 13 is ‘Yes’)	<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	
13b. Do you have documentation of the disability and severity on file? (Required if question 13 is ‘Yes’)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
13c. Are you currently receiving services or treatment for this condition? (Required if question 13 is ‘Yes’)	<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	
14. Do you feel you currently have a 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	
14a. Do you expect this to be of long–continued and indefinite duration AND substantially impair your ability to live independently? (Required if question 14 is ‘Yes’)	<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	
14b. Do you have documentation of the disability and severity on file? (Required if question 14 is ‘Yes’)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
14c. Are you currently receiving services or treatment for this condition? (Required if question 14 is ‘Yes’)	<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	
15. Have you been a victim of domestic violence or a victim of intimate partner violence?	<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	
15a. How long ago did you have this experience? (Required if question 15 is ‘Yes’)	<input type="checkbox"/> Within the past three months <input type="checkbox"/> Three to six months ago (excluding six months exactly) <input type="checkbox"/> From six to twelve months ago (excluding one year exactly) <input type="checkbox"/> More than a year ago <input type="checkbox"/> Client Doesn’t Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected		
15b. Are you currently fleeing? (Required if question 15 is ‘Yes’)	<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	

EMPLOYMENT: For adults 18 and older or Head of Household < 18 years old, required questions shaded

Question	Check One Answer	Comments
16. Are you currently employed?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn’t Know <input type="checkbox"/> Client Refused
16a. Why are you not employed? (Required if question 16 is ‘No’)	<input type="checkbox"/> Looking for work <input type="checkbox"/> Unable to work <input type="checkbox"/> Not looking for work	
16b. What type of employment do you have? (Required if question 16 is ‘Yes’)	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Seasonal / sporadic (including day labor)	

PREGNANCY - Females who are head of household, 18 and over, or are an unaccompanied youth only

Question	Check One Answer	Comments
17. Are you pregnant?	<input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused	
17a. What is your due date? (Required if question 17 is 'Yes')	____/____/____	

YOUTH - Head of Households aged 17 and under only

Question	Check One Answer	Comments
18. Did you run away from home or a foster care home?	<input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused	

VETERAN - US Veterans only, required questions are shaded

Question	Check One Answer	Comments
19. Which branch of the military did you serve in?	<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	
20. What type of discharge did you receive?	<input type="checkbox"/> Honorable <input type="checkbox"/> General under honorable conditions <input type="checkbox"/> Other than honorable conditions (OTH) <input type="checkbox"/> Bad Conduct <input type="checkbox"/> Dishonorable <input type="checkbox"/> Uncharacterized <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
21. When did you enter military service?	____/____/____ <input type="checkbox"/> Doesn't Know	

NOTE: The following questions are required for SSVF programs, but HIGHLY recommended to be completed for all veterans.

22. When did you separate from military service?	____/____/____ <input type="checkbox"/> Doesn't Know	
23. Household Income as a Percentage of AMI	<input type="checkbox"/> Less than 30% <input type="checkbox"/> 30% to 50% <input type="checkbox"/> Greater than 50%	
24. VAMC Station Score	_____	

Did you serve in any of the following wars/war eras?

25. World War II Dec. 1941 – Dec. 1946	<input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
26. Korean War Jun. 1950 – Jan. 1955	<input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
27. Vietnam War Feb. 1961 – May 1975	<input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	

28. Persian Gulf War (Operation Desert Storm) <i>Aug. 1990 – April 1991</i>	<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	
29. Afghanistan (Operation Enduring Freedom) <i>Oct. 2001 - Present</i>	<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	
30. Iraq (Operation Iraqi Freedom) <i>Mar. 2003 – Aug. 2010</i>	<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	
31. Iraq (Operation New Dawn) <i>Sept. 2010 – Dec. 2011</i>	<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	
32. Other Peace-keeping Operations or Military Interventions (such as Lebanon, Panama, Somalia, Bosnia, Kosovo)	<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	

CHRONIC HOMELESSNESS - Adults aged 18 and older and Head of Household < 18 years old, required questions are shaded

Question	Check One Answer	Comments
<p>ASSESSOR ONLY – DO NOT ASK:</p> <p>33. Is the client chronically homeless?</p> <p><i>To be chronically homeless, the client must be a homeless individual or a family with an adult head of household (or if there is no adult in the family, a minor head of household) with a disability who lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and has been homeless continuously for at least 12 months or on at least 4 separate occasions in the last 3 years where the combined occasions equal at least 12 months</i></p>	<input type="checkbox"/> No <input type="checkbox"/> Yes	

RHY – Required for RHY-Funded Clients ONLY

Question	Check One Answer	Comments
34. Formerly a Ward of the Juvenile Justice System	<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	
34a. If Yes for Formerly a Ward of the Juvenile Justice System, Number of Years (Required if question 34 is 'Yes')	<input type="checkbox"/> Less than one year <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 3 to 5 or more years	
34b. If Less than one year for Number of Years, Number of Months (Required if question 34a is 'Less than one year')	<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 <input type="checkbox"/> 11	
35. Referral Source	<input type="checkbox"/> Self-Referral <input type="checkbox"/> Individual: Parent/Guardian <input type="checkbox"/> Individual: Relative or Friend <input type="checkbox"/> Individual: Other Adult or Youth <input type="checkbox"/> Individual: Partner/Spouse <input type="checkbox"/> Individual: Foster Parent <input type="checkbox"/> Outreach Project: FYSB <input type="checkbox"/> Outreach Project: Other <input type="checkbox"/> Temporary Shelter: FYSB Basic Center Project	

	<input type="checkbox"/> Temporary Shelter: Other Youth Only Emergency Shelter <input type="checkbox"/> Temporary Shelter: Emergency Shelter for Families <input type="checkbox"/> Temporary Shelter: Emergency Shelter for Individuals <input type="checkbox"/> Temporary Shelter: Domestic Violence Shelter <input type="checkbox"/> Temporary Shelter: Safe Place <input type="checkbox"/> Temporary Shelter: Other <input type="checkbox"/> Residential Project: FYSB Transitional Living Project <input type="checkbox"/> Residential Project: Other Transitional Living Project <input type="checkbox"/> Residential Project: Group Home <input type="checkbox"/> Residential Project: Independent Living Project <input type="checkbox"/> Residential Project: Job Corps <input type="checkbox"/> Residential Project: Drug Treatment Center <input type="checkbox"/> Residential Project: Treatment Center <input type="checkbox"/> Residential Project: Educational Institute <input type="checkbox"/> Residential Project: Other Agency project <input type="checkbox"/> Residential Project: Other Project <input type="checkbox"/> Hotline: National Runaway Switchboard <input type="checkbox"/> Hotline: Other <input type="checkbox"/> Other Agency: Child Welfare/CPS <input type="checkbox"/> Other Agency: Non-Residential Independent Living Project <input type="checkbox"/> Other Project Operated by your Agency <input type="checkbox"/> Other Youth Services Agency <input type="checkbox"/> Juvenile Justice <input type="checkbox"/> Law Enforcement/ Police <input type="checkbox"/> Religious Organization <input type="checkbox"/> Mental Hospital <input type="checkbox"/> School <input type="checkbox"/> Other Organization <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not Collected	
<p>35a. If Outreach Project: FYSB is selected for Referral Source, Number of times approached by outreach prior to entering the project (Required if question 35 is Outreach Project: FYSB)</p>	<p>_____ times</p>	
<p>36. Sexual Orientation</p>	<input type="checkbox"/> Heterosexual <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not Collected	
<p>37. Last Grade Completed</p>	<input type="checkbox"/> Less than Grade 5 <input type="checkbox"/> Grades 5-6 <input type="checkbox"/> Grades 7-8 <input type="checkbox"/> Associate's Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Graduate Degree	

	<input type="checkbox"/> Grades 9-11 <input type="checkbox"/> Grade 12/HS Diploma <input type="checkbox"/> GED <input type="checkbox"/> Some College <input type="checkbox"/> School program does not have grade levels	<input type="checkbox"/> Vocational Certification <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not Collected	
38. School Status	<input type="checkbox"/> Attending school regularly <input type="checkbox"/> Attending school irregularly <input type="checkbox"/> Graduated from high school <input type="checkbox"/> Obtained GED <input type="checkbox"/> Dropped Out	<input type="checkbox"/> Suspended <input type="checkbox"/> Expelled <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not Collected	
39. Compared to other people your age, would you say your health is:	<input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair	<input type="checkbox"/> Poor <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not Collected	
40. Mental Health Status	<input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair	<input type="checkbox"/> Poor <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not Collected	
41. Dental Health Status	<input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair	<input type="checkbox"/> Poor <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not Collected	
42. Formerly a Ward of Child Welfare/Foster Care Agency	<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	
42a. If yes for "Formerly a Ward of Child Welfare/Foster Care Agency" Number of Years (Required if question 42 is 'Yes')	<input type="checkbox"/> Less than one year <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 3 to 5 or more years		
42b. If Less than one year for Number of Years, Number of Months (Required if question 42a is 'Less than one year')	<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 <input type="checkbox"/> 11
43. Young person's critical issues	<input type="checkbox"/> Sex/Gender-Youth <input type="checkbox"/> Household dynamics <input type="checkbox"/> Sex/Gender-Family Member <input type="checkbox"/> Housing Issues - Youth <input type="checkbox"/> Housing Issues - Family member <input type="checkbox"/> School- Youth <input type="checkbox"/> School- Family member <input type="checkbox"/> Unemployment - Youth <input type="checkbox"/> Unemployment - Family member <input type="checkbox"/> Mental Health-Youth <input type="checkbox"/> Mental Health-Family member		

	<input type="checkbox"/> Health- Youth <input type="checkbox"/> Health- Family member <input type="checkbox"/> Physical Dsby- Youth <input type="checkbox"/> Physical Dsby- Family member <input type="checkbox"/> Mental Dsby - Youth <input type="checkbox"/> Mental Dsby - Family member <input type="checkbox"/> Abuse – Youth <input type="checkbox"/> Abuse - Family member <input type="checkbox"/> Drug Abuse - Youth <input type="checkbox"/> Drug Abuse - Family member <input type="checkbox"/> Insufficient Income to support youth - Family member <input type="checkbox"/> Active Military Parent - Family member <input type="checkbox"/> Incarcerated Parent of Youth	
43a. If 'Incarcerated Parent of Youth', please specify (Required if question 43 is 'Incarcerated Parent of Youth')	<input type="checkbox"/> One parent/legal guardian is incarcerated <input type="checkbox"/> Both parents/legal guardians are incarcerated <input type="checkbox"/> The only parent/legal guardian is incarcerated	
44. Have you ever received anything in exchange for having sexual relations with another person, such as money, food, drugs or shelter?	<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	
44a. If yes, have you received anything in exchange for having sexual relations with another person in the last three months? (Required if 44 is 'Yes')	<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	
44b. How many times have you received something in exchange for having sexual relations? (Required if 44 is 'Yes')	<input type="checkbox"/> 1 - 3 <input type="checkbox"/> 4 – 7 <input type="checkbox"/> 8 – 11 <input type="checkbox"/> 12 or more <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data not Collected	
44c. Did someone ever make you or persuade you to have sex with anyone else in exchange for something? (Required if 44 is 'Yes')	<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	
44d. If yes, did someone make you or persuade you to have sex with anyone else in exchange for something in the last three months? (Required if question 44c is 'Yes')	<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	
45. Have you ever been afraid to leave or quit a work situation due to fears of violence or other threats of harm to yourself, family or friends?	<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	
45a. Have you ever been promised work where the work or payment was different from what you expected?	<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	
45b. Did you feel forced, pressured or tricked into continuing this job? (Required if question 45 or 45a is 'Yes')	<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	

45c. Have you had any jobs like these in the last three months? (Required if question 45 or 45a is 'Yes')	<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		

I certify that the information above is correct to the best of my knowledge.

Client Signature Site Date

Agency Staff Signature Site Date

DO NOT WRITE IN BOX BELOW - DATA ENTRY PERSONNEL ONLY (Optional):

Date entered into HMIS: ____/____/____

Question	Answer	Initials of Staff completion	Comments
Was the hard copy exit form completely filled out correctly?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Staff Name (verifying completion of Data Entry): _____