



COHMIS

CoC/ESG Intake Form for Project Types:

Emergency Shelter, Safe Haven, Street Outreach

SOCIAL SECURITY NUMBER (SSN)		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
QUALITY OF SSN		<input type="checkbox"/> Full SSN reported <input type="checkbox"/> Approximate/partial SSN reported				<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected				
CLIENT NAME										
Last:		<input type="text"/>								
First:		<input type="text"/>								
Middle:						Suffix:		<input type="text"/>		
QUALITY OF NAME		<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				
DATE OF BIRTH (DOB) (MM/DD/YYYY)		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
QUALITY OF DOB		<input type="checkbox"/> Full DOB reported <input type="checkbox"/> Approximate/partial DOB reported				<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected				
GENDER										
<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Trans Female (MTF or Male to Female) <input type="checkbox"/> Trans Male (FTM or Female to Male) <input type="checkbox"/> Gender Non-Conforming (not exclusively male or female)				<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected				
RACE										
<input type="checkbox"/> White <input type="checkbox"/> Black or African American		<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian				<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected				
ETHNICITY										
<input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Hispanic/Latino		<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected								
VETERAN STATUS										
<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								
RELATIONSHIP TO HEAD OF HOUSEHOLD										
<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								

PROJECT NAME																																											
PROJECT START DATE (MM/DD/YYYY)																																											
Has the client ever experienced homelessness before?	<input type="checkbox"/> No		<input type="checkbox"/> Client doesn't know			<input type="checkbox"/> Data not collected																																					
	<input type="checkbox"/> Yes		<input type="checkbox"/> Client refused																																								
DATE OF ENGAGEMENT	<i>(nbn Shelter & Outreach only)</i>																																										
PRIOR LIVING SITUATION <i>(Where did the client sleep the night before entering this project?) (PICK ONLY 1)</i>																																											
HOMELESS SITUATION																																											
<input type="checkbox"/> Place not meant for human habitation (vehicle, anywhere outside) <input type="checkbox"/> Emergency shelter, including hotel or motel paid for w/ emergency shelter voucher or RHY-funded host home <input type="checkbox"/> Safe Haven																																											
INSTITUTIONAL SITUATION																																											
<input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail, prison or juvenile detention facility																																											
<input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center																																											
TRANSITIONAL & PERMANENT HOUSING SITUATION																																											
<input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Staying or living in a friend's room, apartment, or house <input type="checkbox"/> Staying or living in a family member's room, apartment, or house <input type="checkbox"/> Rental by client, with GPD TIP subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy																																											
<input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons <input type="checkbox"/> Rental by client, with RRH or equivalent subsidy <input type="checkbox"/> Rental by client, with HCV voucher (tenant or project) <input type="checkbox"/> Rental by client in a public housing unit <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy																																											
<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected																																											
LENGTH OF STAY IN PRIOR LIVING SITUATION <i>(How long did the client stay in that situation?)</i>																																											
<input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> One month or more, but less than 90 days <input type="checkbox"/> 90 days or more, but less than one year <input type="checkbox"/> One 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 <i>(for the client's <u>current</u> episode of homelessness)</i>																																											
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="3" style="text-align: center;">MONTH</td> <td colspan="3" style="text-align: center;">DAY</td> <td colspan="5" style="text-align: center;">YEAR</td> </tr> </table>																																	MONTH			DAY			YEAR				
MONTH			DAY			YEAR																																					
Number of times the client has been on the streets, in ES, or Safe Haven in the past three years including today <i>(Regardless of where they stayed last night)</i>																																											
<input type="checkbox"/> One time <input type="checkbox"/> Two times <input type="checkbox"/> Three times <input type="checkbox"/> Four or more times <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 streets, in ES, or SH in the past three years																																											
<input type="checkbox"/> One month (first time) <input type="checkbox"/> Two months <input type="checkbox"/> Three months <input type="checkbox"/> Four months <input type="checkbox"/> Five months <input type="checkbox"/> Six months <input type="checkbox"/> Seven months <input type="checkbox"/> Eight months <input type="checkbox"/> Nine months <input type="checkbox"/> Ten months <input type="checkbox"/> Eleven months <input type="checkbox"/> Twelve 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	
<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
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
*If YES for Physical Disability <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</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
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
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
*If YES for Chronic Health Condition <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</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
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
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
*If YES for Mental Health Problem <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</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
SUBSTANCE ABUSE PROBLEM	
<input type="checkbox"/> No <input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Drug abuse <input type="checkbox"/> Both alcohol and drug abuse	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
*If YES for Substance Abuse Problem <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</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

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
*If YES to Domestic Violence Victim/Survivor		
When did this experience occur?	<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
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

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

NON-CASH BENEFITS	
Receiving Non-Cash Benefits?	<input type="checkbox"/> No <input type="checkbox"/> Yes* <div style="float: right;"> <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected </div>
*If YES to Receiving Non-Cash Benefits – Indicate all sources that apply	
<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) <input type="checkbox"/> TANF Transportation Services <input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) <input type="checkbox"/> Other TANF-Funded Services <input type="checkbox"/> TANF Childcare Services <input type="checkbox"/> Other Non-Cash Benefit (Specify source: _____)	

HEALTH INSURANCE	
Covered by Health Insurance?	<input type="checkbox"/> No <input type="checkbox"/> Yes* <div style="float: right;"> <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected </div>
*If YES to Covered by Health Insurance – Indicate all sources that apply	
<input type="checkbox"/> Medicaid <input type="checkbox"/> Health Insurance Obtained Through COBRA <input type="checkbox"/> Medicare <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Veteran's Administration (VA) Medical Services <input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Employer-Provided Health Insurance <input type="checkbox"/> Other Health Insurance (Specify source: _____)	

Would you like to share the reasons or factors you feel contributed to your homelessness?	<input type="checkbox"/> No <input type="checkbox"/> Yes*
*If YES please indicate all reasons that apply	
<input type="checkbox"/> Abuse or violence in my home <input type="checkbox"/> Lost a job, could not find work <input type="checkbox"/> Alcohol or substance use problems <input type="checkbox"/> Medical Expenses <input type="checkbox"/> Asked to leave or evicted <input type="checkbox"/> Mental health condition <input type="checkbox"/> Bad credit <input type="checkbox"/> Moved to find work <input type="checkbox"/> Client Choice <input type="checkbox"/> Problems with public benefits <input type="checkbox"/> COVID-19 <input type="checkbox"/> PTSD <input type="checkbox"/> Disabling conditions <input type="checkbox"/> Reasons related to my race or ethnicity <input type="checkbox"/> Discharged from foster care <input type="checkbox"/> Reasons related to my sexual orientation or gender identity <input type="checkbox"/> Discharged from jail <input type="checkbox"/> Relationship problems or family breakup <input type="checkbox"/> Discharged from prison <input type="checkbox"/> Traumatic brain injury <input type="checkbox"/> Family member or personal illness <input type="checkbox"/> Unable to pay rent or mortgage <input type="checkbox"/> Language barrier <input type="checkbox"/> Unable to pay utilities <input type="checkbox"/> Legal problems <input type="checkbox"/> Other reason (Please specify: _____)	

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

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

Signature of applicant stating all information is true and correct

Date