



COHMIS

RHY Intake Form

SOCIAL SECURITY NUMBER (SSN)									
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:									
First:									
Middle:						Suffix:			
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)									
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 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 (Street Outreach Only)										
PRIOR LIVING SITUATION (Where did the client sleep the night before entering this project?) (PICK ONLY 1)										
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 (How long did the client stay in that situation?)										
<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										
If client is enrolling in RHY Street Outreach or RHY Shelter, or Prior Living Situation = HOMELESS										
APPROXIMATE DATE HOMELESSNESS STARTED										
					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 (Regardless of where they stayed last night)										
<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										

If Client's Prior Living Situation is any INSTITUTIONAL SITUATION:

Length of Stay Less than 90 days?

(Indicate if the stay in the Institutional setting they lived in immediately prior to project entry was less than 90 days)

- No
 Yes*

***If YES to Length of Stay Less than 90 days**

On the night before – stayed on the Streets, Emergency Shelter, or Safe Haven?

(On the night before the client's stay of less than 90 days in an institutional setting, or less than 7 nights in a transitional/permanent housing setting, were they on the Streets, in an Emergency Shelter, or in a Safe Haven?)

- No
 Yes*

***If YES to 'On the night before – stayed on the Streets, Emergency Shelter, or Safe Haven'**

APPROXIMATE DATE HOMELESSNESS STARTED

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 (Regardless of where they stayed last night)

- | | | |
|------------------------------------|---|--|
| <input type="checkbox"/> One time | <input type="checkbox"/> Three times | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Two times | <input type="checkbox"/> Four or more times | <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"/> Five months | <input type="checkbox"/> Nine months | <input type="checkbox"/> More than 12 months |
| <input type="checkbox"/> Two months | <input type="checkbox"/> Six months | <input type="checkbox"/> Ten months | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Three months | <input type="checkbox"/> Seven months | <input type="checkbox"/> Eleven months | <input type="checkbox"/> Client refused |
| <input type="checkbox"/> Four months | <input type="checkbox"/> Eight months | <input type="checkbox"/> Twelve months | <input type="checkbox"/> Data not collected |

If Client's Prior Living Situation is any TRANSITIONAL or PERMANENT HOUSING SITUATION:

Length of Stay Less than 7 nights?

(Indicate if the stay in the Transitional or Permanent Housing setting they lived in immediately prior to project entry was less than 7 nights)

- No
 Yes*

***If YES to Length of Stay Less than 7 nights**

On the night before – stayed on the Streets, Emergency Shelter, or Safe Haven?

(On the night before the client's stay of less than 7 nights in a Transitional or Permanent Housing setting, were they on the Streets, in an Emergency Shelter, or in a Safe Haven?)

- No
 Yes*

***If YES to 'On the night before – stayed on the Streets, Emergency Shelter, or Safe Haven'**

APPROXIMATE DATE HOMELESSNESS STARTED

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 (Regardless of where they stayed last night)

- | | | |
|------------------------------------|---|--|
| <input type="checkbox"/> One time | <input type="checkbox"/> Three times | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Two times | <input type="checkbox"/> Four or more times | <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"/> Five months | <input type="checkbox"/> Nine months | <input type="checkbox"/> More than 12 months |
| <input type="checkbox"/> Two months | <input type="checkbox"/> Six months | <input type="checkbox"/> Ten months | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Three months | <input type="checkbox"/> Seven months | <input type="checkbox"/> Eleven months | <input type="checkbox"/> Client refused |
| <input type="checkbox"/> Four months | <input type="checkbox"/> Eight months | <input type="checkbox"/> Twelve months | <input type="checkbox"/> Data not collected |

RHY-BCP STATUS (BCP-Prevention & BCP-Emergency Shelter Only)**DATE OF STATUS DETERMINATION**

MONTH			DAY			YEAR			

FYSB YOUTH ELIGIBLE FOR RHY SERVICES
 No* Yes*
***If NO for FYSB YOUTH – Reason services are not funded by BCP grant**
 Ward of the State-Immediate Reunification Out of age range
 Ward of the criminal justice system-immediate reunification Other _____
***If YES for FYSB YOUTH Runaway Youth?**
 No Client doesn't know
 Yes Client refused
 Data not collected
DISABLING CONDITION
 No Client doesn't know
 Yes Client refused
 Data not collected
PHYSICAL DISABILITY
 No Client doesn't know
 Yes* Client refused
 Data not collected
***If YES for Physical Disability**

Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

 No Client doesn't know
 Yes Client refused
 Data not collected
DEVELOPMENTAL DISABILITY
 No Client doesn't know
 Yes Client refused
 Data not collected
CHRONIC HEALTH CONDITION
 No Client doesn't know
 Yes* Client refused
 Data not collected
***If YES for Chronic Health Condition**

Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

 No Client doesn't know
 Yes Client refused
 Data not collected
MENTAL HEALTH PROBLEM
 No Client doesn't know
 Yes* Client refused
 Data not collected
***If YES for Mental Health Problem**

Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

 No Client doesn't know
 Yes Client refused
 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

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"/> Client doesn't know	<input type="checkbox"/> Client refused
	<input type="checkbox"/> Yes*	<input type="checkbox"/> Data not collected	
*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"/> Other TANF-Funded Services	<input type="checkbox"/> Other Non-Cash Benefit
<input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	<input type="checkbox"/> TANF Childcare Services	(Specify source: _____)	

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

SEXUAL ORIENTATION			
<input type="checkbox"/> Heterosexual	<input type="checkbox"/> Bisexual	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
<input type="checkbox"/> Gay	<input type="checkbox"/> Questioning/Unsure	<input type="checkbox"/> Data not collected	
<input type="checkbox"/> Lesbian	<input type="checkbox"/> Other _____		

LAST GRADE COMPLETED			
<input type="checkbox"/> Less than Grade 5	<input type="checkbox"/> School does not have grade levels	<input type="checkbox"/> Bachelor's degree	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Grades 5-6	<input type="checkbox"/> GED	<input type="checkbox"/> Graduate Degree	<input type="checkbox"/> Client refused
<input type="checkbox"/> Grades 7-8	<input type="checkbox"/> Some College	<input type="checkbox"/> Vocational Certification	<input type="checkbox"/> Data not collected
<input type="checkbox"/> Grades 9-11	<input type="checkbox"/> Associate's Degree		
<input type="checkbox"/> Grade 12			

SCHOOL STATUS			
<input type="checkbox"/> Attending school regularly	<input type="checkbox"/> Dropped out	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
<input type="checkbox"/> Attending school irregularly	<input type="checkbox"/> Suspended	<input type="checkbox"/> Data not collected	
<input type="checkbox"/> Graduate from high school	<input type="checkbox"/> Expelled		
<input type="checkbox"/> Obtained GED			

EMPLOYMENT STATUS										
Employed?		<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 Employed										
Type of Employment		<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		<input type="checkbox"/> Seasonal/sporadic (including day labor)						
*If NO to Employed										
Why not employed?		<input type="checkbox"/> Looking for work <input type="checkbox"/> Unable to work		<input type="checkbox"/> Not looking for work						
GENERAL 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						
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						
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						
PREGNANCY STATUS										
<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 Pregnancy Status, Due Date:										
				MONTH		DAY		YEAR		
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								
If YES for Formerly a Ward, Number of Years:				<input type="checkbox"/> Less than one year <input type="checkbox"/> 1 to 2 years		<input type="checkbox"/> 3 to 5 years or more				
*If Less than one year for Number of Years, Number of Months (1-11)										

FORMERLY A WARD OF 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
If YES for Formerly a Ward, Number of Years:	<input type="checkbox"/> Less than one year <input type="checkbox"/> 1 to 2 years	<input type="checkbox"/> 3 to 5 years or more
*If Less than one year for Number of Years, Number of Months (1-11)		
FAMILY CRITICAL ISSUES		
Unemployment – Family Member	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Mental health issues – Family Member	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Physical disability – Family Member	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Abuse and neglect – Family Member	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Insufficient income to support youth – Family Member	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Incarcerated parent of youth	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Referral Source	
<input type="checkbox"/> Self-referral <input type="checkbox"/> Individual: Parent/Guardian/ Relative/ Friend/ Foster Parent/ Other Individual <input type="checkbox"/> Outreach project* <input type="checkbox"/> Temporary shelter <input type="checkbox"/> Residential project <input type="checkbox"/> Hotline <input type="checkbox"/> Child welfare/CPS	<input type="checkbox"/> Juvenile justice <input type="checkbox"/> Law enforcement/Police <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

*If Street Outreach project, Number of times approached by Outreach prior to entering project:	
---	--

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"/> Alcohol or substance use problems <input type="checkbox"/> Asked to leave or evicted <input type="checkbox"/> Bad credit <input type="checkbox"/> Client Choice <input type="checkbox"/> COVID-19 <input type="checkbox"/> Disabling conditions <input type="checkbox"/> Discharged from foster care <input type="checkbox"/> Discharged from jail <input type="checkbox"/> Discharged from prison <input type="checkbox"/> Family member or personal illness <input type="checkbox"/> Language barrier <input type="checkbox"/> Legal problems	<input type="checkbox"/> Lost a job, could not find work <input type="checkbox"/> Medical Expenses <input type="checkbox"/> Mental health condition <input type="checkbox"/> Moved to find work <input type="checkbox"/> Problems with public benefits <input type="checkbox"/> PTSD <input type="checkbox"/> Reasons related to my race or ethnicity <input type="checkbox"/> Reasons related to my sexual orientation or gender identity <input type="checkbox"/> Relationship problems or family breakup <input type="checkbox"/> Traumatic brain injury <input type="checkbox"/> Unable to pay rent or mortgage <input type="checkbox"/> Unable to pay utilities <input type="checkbox"/> Other reason (Please specify: _____)

PIKES PEAK CoC ENTRY QUESTIONS	
Did you relocate to Colorado/Colorado Springs?	
<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 , why? (select all that apply)	
<input type="checkbox"/> Care of sick relative <input type="checkbox"/> Climate <input type="checkbox"/> Colorado marijuana laws <input type="checkbox"/> Driver's Licenses/Identification Cards for Immigrants <input type="checkbox"/> Employment	<input type="checkbox"/> Family Support <input type="checkbox"/> Medical Needs <input type="checkbox"/> Natural Disaster <input type="checkbox"/> Needed services <input type="checkbox"/> Domestic Violence

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