

# MSHMIS Street & Shelter Intake Form (3.917A)

Only Use for Street Outreach, Safe Haven and Emergency Shelter Projects

Intake Date: \_\_\_\_\_

Intake Staff/Case Manager: \_\_\_\_\_

## HOUSEHOLD INFORMATION

Answer this section for all persons in household (use additional sheets for larger families)

Full Name	Relationship to Head of Household	SSN	US Military Veteran	Date of Birth <i>mm/dd/yyyy</i>	Gender	Race <i>(Select all that apply)</i>
<p>_____</p> <p><b><u>Name Data Quality</u></b>  <input type="checkbox"/> Full name  <input type="checkbox"/> Partial, street or code name  <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused</p>	<p><input type="checkbox"/> Self (Head of household)</p>	<p>_____</p> <p><b><u>SSN Data Quality</u></b>  <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</p>	<p style="color: red; font-weight: bold;"><i>(Answer for adults 18+ only)</i></p> <p><input type="checkbox"/> Yes  <input type="checkbox"/> No  <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused</p>	<p style="text-align: center;">/ /</p> <p><b><u>DOB Data Quality</u></b>  <input type="checkbox"/> Full DOB reported  <input type="checkbox"/> Approximate or partial DOB  <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused</p>	<p><input type="checkbox"/> Female  <input type="checkbox"/> Male  <input type="checkbox"/> Transgender male to female  <input type="checkbox"/> Transgender female to male  <input type="checkbox"/> Doesn't identify as male, female or transgender  <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused</p>	<p><input type="checkbox"/> American Indian or Alaskan Native  <input type="checkbox"/> Asian  <input type="checkbox"/> Black or African American  <input type="checkbox"/> Native Hawaiian or other Pacific Islander  <input type="checkbox"/> White  <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused</p>
<p>_____</p> <p><b><u>Name Data Quality</u></b>  <input type="checkbox"/> Full name  <input type="checkbox"/> Partial, street or code name  <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused</p>	<p><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 (other relation to head of household)  <input type="checkbox"/> Other: non-relation member</p>	<p>_____</p> <p><b><u>SSN Data Quality</u></b>  <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</p>	<p style="color: red; font-weight: bold;"><i>(Answer for adults 18+ only)</i></p> <p><input type="checkbox"/> Yes  <input type="checkbox"/> No  <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused</p>	<p style="text-align: center;">/ /</p> <p><b><u>DOB Data Quality</u></b>  <input type="checkbox"/> Full DOB reported  <input type="checkbox"/> Approximate or partial DOB  <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused</p>	<p><input type="checkbox"/> Female  <input type="checkbox"/> Male  <input type="checkbox"/> Transgender male to female  <input type="checkbox"/> Transgender female to male  <input type="checkbox"/> Doesn't identify as male, female or transgender  <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused</p>	<p><input type="checkbox"/> American Indian or Alaskan Native  <input type="checkbox"/> Asian  <input type="checkbox"/> Black or African American  <input type="checkbox"/> Native Hawaiian or other Pacific Islander  <input type="checkbox"/> White  <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused</p>
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### HOUSEHOLD INFORMATION continued...

Answer this section for all persons in household (use additional sheets for larger families)

Name <i>(Answer for All Persons in HH)</i>	Ethnicity	Does the client have a disabling condition?	If client has a disabling condition, please answer the following sub-assessment questions:					
			<i>Disability Type (Select all that apply)</i>	<i>Disability Determination</i>	<i>If Yes, to be long-continued and indefinite duration and substantially impairs ability to live independently?</i>	<i>Documentation of Disability and Severity on File</i>	<i>Currently Receiving Services/ Treatment for this disability</i>	<i>Long Term (Yes/No)</i>
	<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"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't Know <input type="checkbox"/> Client refused	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problems <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<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"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't Know <input type="checkbox"/> Client refused	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problems <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<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"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't Know <input type="checkbox"/> Client refused	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problems <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Disability Notes:** \_\_\_\_\_

### HOUSEHOLD INFORMATION continued...

Answer this section for all persons in the household (use additional sheets for larger families)

Name <i>(Answer for All Persons in HH)</i>	Pregnant	Currently Covered by Health Insurance?	<i>(If Client has Health Insurance)</i> Select All Type(s) That Apply
	<input type="checkbox"/> Yes <input type="checkbox"/> No  <i>(If Yes)</i> <b>Projected Date of Birth</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Veteran 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 (Please Specify: _____)
	<input type="checkbox"/> Yes <input type="checkbox"/> No  <i>(If Yes)</i> <b>Projected Date of Birth</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Veteran 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 (Please Specify: _____)
	<input type="checkbox"/> Yes <input type="checkbox"/> No  <i>(If Yes)</i> <b>Projected Date of Birth</b> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Veteran 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 (Please Specify: _____)

## Homeless History Interview

**Answer the following questions for ALL Household Members**  
**(Use additional sheets if members of the same household have different homeless histories)**

*Chronic status is determined by a client's history of homelessness, disability status, and the length of time spent on the street, in an emergency shelter or safe haven. Requires a substantiated disability and, continuously homeless for past 12 months to qualify or 4 separate occasions in the past 3 years as long as the combined occasions total at least 12 months. Intake workers should not instruct the client on the length of time/# of episodes necessary to qualify as chronically homeless. Questions should be asked in the exact order they are presented below.*

### Describe the client's living situation (immediately) prior to project entry?

Literally Homeless Situation	Institutional Situation	Transitional/Permanent Housing Situation	Don't Know/Refused
<input type="checkbox"/> Place not meant for habitation (e.g. a vehicle, abandoned building, bus/train/subway station, airport, anywhere outside).  <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher.  <input type="checkbox"/> Safe Haven  <input type="checkbox"/> Interim Housing (e.g. client applied for permanent housing and a unit/voucher has been reserved but client is not able to move in immediately).	<input type="checkbox"/> Foster care home or foster 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	<input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Permanent housing for formerly homeless persons (such as CoC Project) <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Rental by client, with GPD TIP subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Residential project of halfway house with no homeless criteria <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> Staying or living in a friend's room, apartment or house <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth)	<input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused

### 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                      |  |

*Have the client look back to the date of the last time s(he) "had a place to sleep **other than** the streets, ES, or SH".*

*If the client knows the month and year but not the day, the worker may substitute the day of the month with the same day of the month as project entry.*

#### What Counts as a Break in Homelessness?

*As the client looks back, there may be breaks in their stay on the streets, ES, or SH. A break in homelessness is considered to be:*

- **7 or more consecutive nights in a Housing Situation** (see Section III above).
- **90 or more consecutive days in an Institutional Situation** (see Section II above)

*Follow-up questions:*

1. "Did you stay anywhere other than on the streets, in emergency shelter, or safe haven for less than 7 nights" (if not an institution). or
2. "Were you in jail/hospital/other Institution less 90 days" (if break is an institution).

**If 1 or 2 is yes, include all those days in the client's total number of days homeless and continue back to the next break in homelessness.**

Approximate date homelessness started: \_\_\_\_\_(M/D/YYYY)

Regardless of where they stayed last night -- Number of times the client has been on the streets, in ES, or SH in the past three years, including today

- |                                    |   |  |
|------------------------------------|---|--|
| <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      |

Total number of months homeless (on the street, in emergency shelter or safe haven) in the past 3 years?

(e.g. # of cumulative, but not necessarily consecutive months spent homeless)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> One month (this time is the first month)    | <input type="checkbox"/> More than 12 months | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> 2 – 12 months → Must specify # months _____ |  | <input type="checkbox"/> Client refused      |

Answer the following questions for all Household Members (Unless Otherwise Specified)

**Housing Status**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Category 1 - Homeless                           | <input type="checkbox"/> Category 3 – Homeless only under other federal statuses | <input type="checkbox"/> Stably Housed       |
| <input type="checkbox"/> Category 2 – At imminent risk of losing housing | <input type="checkbox"/> Category 4 – Fleeing domestic violence                  | <input type="checkbox"/> Client doesn't know |
|  | <input type="checkbox"/> At-risk of homelessness                                 | <input type="checkbox"/> Client refused      |

Zip Code of Last Permanent Address: \_\_\_\_\_ City of Residence: \_\_\_\_\_ County of Residence: \_\_\_\_\_

Client Location (CoC Code): \_\_\_\_\_ (Answer for Head of Household Only)

**\*\*Answer the following questions for HEAD OF HOUSEHOLD and ADULTS only! (Print additional pages where needed) \*\***

**DOMESTIC VIOLENCE**

Domestic Violence Victim/Survivor should be indicated as “Yes” if the person has experienced any domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has taken place **within the individual's or family's primary nighttime residence.**

**Domestic Violence Victim/Survivor?**

- |                              |  |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> No  | <input type="checkbox"/> Client refused      |

**(If yes) When Experience Occurred**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Within the past three months                           | <input type="checkbox"/> Six months to one year ago (excluding one year exactly) | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Three to six months ago (excluding six months exactly) | <input type="checkbox"/> One year ago or more                                    | <input type="checkbox"/> Client refused      |

Currently fleeing should be indicated as “Yes” if the Person is fleeing, or is attempting to flee, the domestic violence situation or is afraid to return to their primary nighttime residence.

**(If yes) Are you currently fleeing?**

- Yes
  Client doesn't know  
 No
  Client refused

**Overview of domestic violence**

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**INCOME & NON-CASH BENEFITS**

**Currently receiving income from any source?**

- Yes
  Client refused  
 No
  Client doesn't know

X	Source of Income (Monthly)	Family Member	Amount from Source
	Alimony or Other Spousal Support		\$ .00
	Child Support		\$ .00
	Earned Income ( <i>Employment</i> )		\$ .00
	General Assistance		\$ .00
	Pension or Retirement Income from a Former Job		\$ .00
	Private Disability Insurance		\$ .00
	Retirement Income from Social Security		\$ .00
	SSDI ( <i>Social Security Disability Income</i> )		\$ .00
	SSI ( <i>Supplemental Security Income</i> )		\$ .00
	TANF ( <i>Temporary Assistance for Needy Families or FIP grant</i> )		\$ .00
	Unemployment Insurance		\$ .00
	VA Service-Connected Disability Compensation		\$ .00
	VA Non-Service-Connected Disability Pension		\$ .00
	Workers Compensation		\$ .00
	Other ( <i>Including Gifts from Friends and Family</i> ) <b>Specify:</b> _____		\$ .00
	<b>No Financial Resources</b>		<b>N/A</b>

**Total Monthly Income \$ \_\_\_\_\_ (Per Household Member)**

**Currently receiving any non-cash benefits?**

- Yes
- No

- Client doesn't know
- Client refused

<b>X</b>	<b>Source of Non-Cash Benefit (Monthly)</b>	<b>Family Member</b>	<b>Amount (If applicable)</b>
	Supplemental Nutrition Assistance Program ( <i>Food Stamps</i> )		\$ .00
	Special Supplemental Nutrition Program for WIC		\$ .00
	TANF Child Care Services		\$ .00
	TANF Transportation Services		\$ .00
	Other TANF Funded Services		\$ .00
	Section 8, Public Housing or rental assistance		\$ .00
	Temporary Rental Assistance		\$ .00
	Other Source – <b>Specify:</b> _____		\$ .00

**Connection With SOAR?**

- Yes
- No

- Client doesn't know
- Client refused

**CONTACT INFORMATION**

To obtain the client's emergency contact information, intake staff should ask the client, "If you wish to be contacted regarding benefits that you may be eligible for or in the case of an emergency, we will need your best Contact Information. Some services are very time limited so please be as accurate as possible and include how we might reach you even as your circumstances are changing."

Client's Cell Phone Number \_\_\_\_\_

Emergency Contact's Name \_\_\_\_\_

Contact Type (Relationship to Client) \_\_\_\_\_

Phone Number \_\_\_\_\_

Second Phone Number \_\_\_\_\_

Email Address \_\_\_\_\_

Contact's Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Contact's Zip Code \_\_\_\_\_

**CONTACTS & ENGAGEMENT**  
**(REQUIRED FOR ALL STREET OUTREACH AND NBN SHELTERS)**

Street Outreach Projects and Emergency Shelters using the Night-by-Night Method of Tracking MUST record the date and location of EACH CONTACT made with clients including the 'Date of Engagement'.  
 Please see the *HMIS Data Collection – Street Outreach Supplemental Form* and *2014 HUD Data Standards* for more information.

**FUNDER/PROJECT SPECIFIC QUESTIONS**  
**DHS-ESP ONLY**

*Only answer questions in this box if your agency receives ESP-TANF funding from DHS or through The Salvation Army (Required for ALL clients)*

<p>Referred from HARA? <input type="checkbox"/> Yes <input type="checkbox"/> No                  → If No, Date Client Referred to HARA: ___ / ___ / _____</p> <p>TANF Eligible Family? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>ESP Billing Status:</b></p> <p><input type="checkbox"/> Bill ESP for this Client  <input type="checkbox"/> Do Not Bill ESP for this Client  <input type="checkbox"/> Health Care for Homeless Vets Qualified  <input type="checkbox"/> Not Applicable</p>	<p># in Household _____</p> <p># Adults in HH _____</p> <p># Children in HH _____</p>
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**DHS ESP Motel Funding Request**  
**Motel Programs HoH ONLY**  
*(One line for each Funding Request)*

Total Hotel/ Motel Amount	Coverage Start Date	Coverage End Date	ESP Hotel/Motel Vendor Name	County of ESP Hotel/Motel:
\$ .				
\$ .				