

# MSHMIS CoC Intake Form (3.917B)

For SSO, TH, PH, & PSH 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 mm/dd/yyyy	Gender	Race <i>(Select all that apply)</i>
<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <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>	<input type="checkbox"/> Self (Head of household)	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <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; text-align: center;"><i>(Answer for adults 18+ only)</i></p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<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>	<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 (i.e. not exclusively male to female) <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<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
<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <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>	<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	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <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; text-align: center;"><i>(Answer for adults 18+ only)</i></p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<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>	<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 (i.e. not exclusively male to female) <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<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
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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?	Disability Type <i>(Select all that apply)</i>	If client has a disabling condition, please answer the following sub-assessment questions. Removed Doc of disability and severity of needs and Currently receiving services columns.		
				Disability Determination	If Yes, to be long-continued and indefinite duration and substantially impairs ability to live independently?	Long Term (Yes/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"/> 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"/> 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

**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 the Head of Household and Adults**  
**(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?

**(Select one Living Situation and answer the corresponding questions in the order in which they appear)**

	Literally Homeless Situation	Institutional Situation	Transitional/Permanent Housing Situation	Don't Know/ Refused
<b>SECTION I</b>	<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 (other than RRH) for formerly homeless persons  <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 housing subsidy (including RRH)  <input type="checkbox"/> Residential project or 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

SECTION II	<b>Length of Stay in Prior Living Situation (i.e. the literally homeless situation identified above)?</b> One night or less Two to six nights 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	<b>Length of Stay in Prior Living Situation (i.e. the institutional situation identified above)?</b> <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 <b>Did you stay in the institutional situation less than 90 days?</b> <input type="checkbox"/> Yes (If YES – Complete SECTION III) <input type="checkbox"/> No (If NO- End Homeless History Interview)	<b>Length of Stay in Prior Living Situation (i.e. the housing situation identified above)</b> 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 <b>Did you stay in the housing situation less than 7 nights?</b> Yes (If YES – Complete SECTION III) No (If NO – End Homeless History Interview)	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
SECTION III	N/A <b>Complete SECTION IV Below</b>	<b>On the night before entering the institutional situation did you stay on the streets, in emergency shelter or a safe haven?</b> <input type="checkbox"/> Yes (If YES – Complete SECTION IV) <input type="checkbox"/> No (If NO- End Homeless History Interview)	<b>On the night before entering the housing situation did you stay on the streets, in emergency shelter or a safe haven?</b> Yes (If YES – Complete SECTION IV) No (If NO – End Homeless History Interview)	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
<p>Have the client look back to the date of the last time s(he) "had a place to sleep <b>other than</b> 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.</p> <p><u>What Counts as a Break in Homelessness?</u>          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:</p> <ul style="list-style-type: none"> <li>• 7 or more consecutive nights in a Housing Situation (see Section III above).</li> <li>• 90 or more consecutive days in an Institutional Situation (see Section II above)</li> </ul> <p>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).</p> <p><b>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.</b></p>				
SECTION IV	<b>Approximate date homelessness started:</b> _____ (M/D/YYYY) <b>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</b> <input type="checkbox"/> One Time <input type="checkbox"/> Two Times <input type="checkbox"/> Three Times <input type="checkbox"/> Four or more Times <b>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)</b> <input type="checkbox"/> One month (this time is the first month) <input type="checkbox"/> 2 – 12 months → Must specify # months _____ <input type="checkbox"/> More than 12 months			<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused

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

**Housing Status**

- Category 1 - Homeless
- Category 2 – At imminent risk of losing housing
- Category 3 – Homeless only under other federal statuses
- Category 4 – Fleeing domestic violence
- At-risk of homelessness
- Stably Housed
- Client doesn't know
- Client refused

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

**Answer the following questions for Head of Household Only**

Client Location (CoC Code): \_\_\_\_\_

**(Required for all PH and RRH Projects)**

*This question differentiates between clients who are awaiting placement and those who have moved into any type of permanent housing, regardless of funding source or whether the project is providing rental assistance. The Housing Move-In Date MUST be entered via an Interim Assessment with a timestamp that occurs after the Project Start and before the Project Exit. If client is **not** in housing leave this question blank.*

Housing Move-In Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**\*\*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?**

- Yes
- No
- Client doesn't know
- Client refused

**(If yes) When Experience Occurred**

- Within the past three months
- Three to six months ago (excluding six months exactly)
- Six months to one year ago (excluding one year exactly)
- One year ago or more
- Client doesn't know
- 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
- No
- Client doesn't know
- Client refused

**Overview of domestic violence**

## INCOME & NON-CASH BENEFITS

Currently receiving income from any source?

- Yes  
 No

- Client doesn't know  
 Client refused

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 Insurance</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> ) Specify:___		\$ .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

X	Source of Non-Cash Benefit (Monthly)	Family Member	Amount (If applicable)
	Supplemental Nutrition Assistance Program (SNAP) (Previously known as Food Stamps)		\$ .00
	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)		\$ .00
	TANF Child Care Services		\$ .00
	TANF Transportation Services		\$ .00
	Other TANF Funded Services		\$ .00
	Other Source – Specify:___		\$ .00

Connection With SOAR?

- Yes  
 No

## 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 \_\_\_\_\_

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 \_\_\_\_\_



## FUNDER 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)*

Referred from HARA?  Yes  No

→ If No, Date Client Referred to HARA: \_\_\_\_/\_\_\_\_/\_\_\_\_

TANF Eligible Family?  Yes  No

**ESP Billing Status:**

- Bill ESP for this Client
- Do Not Bill ESP for this Client
- Health Care for Homeless Vets Qualified
- Not Applicable

# in Household \_\_\_\_\_

# Adults \_\_\_\_\_

# Children \_\_\_\_\_