MSHMIS Youth Shelter Intake Form

Basic Center – Emergency Shelters

Entrance Date:_____ **Client ID#:**_____ **Case Manager:**_____

First Name:_____ **Middle Name:**_____ **Last Name:**_____

Name Data Quality

- ☐ Full name reported
- ☐ Partial, street name or code name reported
- ☐ Client doesn't know
- ☐ Client refused

SSN#:_____

SSN Data Quality

- ☐ Full SSN Reported
- ☐ Approximate or partial SSN Reported
- ☐ Client doesn't know
- ☐ Client refused

U.S. Military Veteran (Active Duty) – *Answer for youth 18 and older*

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

BASIC DEMOGRAPHIC INFORMATION

Relationship to Head of Household

(Head of Household = Primary Client)

- ☐ Self (head of household)
- ☐ Head of household's child
- ☐ Head of household's spouse or partner
- ☐ Head of household's other relation member
- ☐ Other: non-relation member

Date of Birth_____ (mm/dd/yyyy)

Date of Birth Type

- ☐ Full DOB Reported
- ☐ Approximate or partial DOB Reported
- ☐ Client doesn't know
- ☐ Client refused

Gender

- ☐ Female
- ☐ Male
- ☐ Trans Female (Male to Female)
- ☐ Trans Male (Female to Male)
- ☐ Gender Non-Conforming (i.e. not exclusively male or female)
- ☐ Client doesn't know
- ☐ Client refused

Race *(Select All)*

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Client doesn't know
- ☐ Client refused

Ethnicity

- ☐ Non-Hispanic/Non-Latino
- ☐ Hispanic/Latino
- ☐ Client doesn't know
- ☐ Client refused

Sexual Orientation

- ☐ Heterosexual
- ☐ Gay
- ☐ Lesbian
- ☐ Bisexual
- ☐ Questioning/Unsure
- ☐ Client doesn't know
- ☐ Client refused

Parental Engagement in Care

- ☐ No involvement
- ☐ Limited
- ☐ Moderate
- ☐ Strong
- ☐ Unknown

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

FOSTER CARE INFORMATION

Formerly a Ward of Child Welfare/Foster Care Agency

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

***(If yes)* Number of Years** *(in Child Welfare/Foster Care)*

- ☐ Less than one year
- ☐ 1 to 2 years
- ☐ 3 to 5 or more years

If Less than one year, Number of Months *(in Child Welfare/Foster Care)*: _____

Formerly a Ward of Juvenile Justice System

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

***(If yes)* Number of Years** *(in Juvenile Justice System)*

- ☐ Less than one year
- ☐ 1 to 2 years
- ☐ 3 to 5 or more years

If Less than one year, Number of Months *(in Juvenile Justice System)*: _____

The state HYR Contract requires that 25% of all youth served in Transitional Living Programs are "aged out or aging out" of Foster Care, or were previously in foster care and experiencing homelessness as a result of a dissolved guardianship or adoption.

Transitioned from foster care at the age of 17 or older?

- ☐ Yes
- ☐ No

Was in foster care at age of 14 or older?

- ☐ Yes
- ☐ No

Adopted youth where adoption is at risk of failing or has dissolved?

- ☐ Yes
- ☐ No

In a legal guardianship as a result of foster care and the guardianship ended at age 18 or older and youth is homeless?

- ☐ Yes
- ☐ No

Foster Care Youth who voluntarily remained in or returned to Foster Care after 18th birthday who is homeless, at risk of becoming homeless, or at risk of becoming ineligible for the Young Adult Voluntary Foster Care (YAVFC) program?

- ☐ Yes
- ☐ No

Temporary or Permanent Ward of the Court over the age of 16 (under DHHS jurisdiction) and no other placement can be secured?

- ☐ Yes
- ☐ No

HOMELESS HISTORY INTERVIEW

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
☐ Place not meant for habitation (e.g. a vehicle, abandoned building, bus/train/subway station, airport, anywhere outside). ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher. ☐ Safe Haven ☐ 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).	☐ Foster care home or foster 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	☐ 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 (other than RRH) 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 housing subsidy (including RRH) ☐ Residential project of 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 (including homeless youth)	☐ Client doesn't know ☐ Client refused

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

*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**

- ☐ One Time
- ☐ Two Times
- ☐ Three Times
- ☐ Four or more Times
- ☐ Client doesn't know
- ☐ 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)

- ☐ One month (this time is the first month)
- ☐ 2 – 12 months → Must specify # months____
- ☐ More than 12 months
- ☐ Client doesn't know
- ☐ Client refused

Housing Status

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

Client Location *(CoC Code):* _____

Zip Code of Last Permanent Address: _____

City of Residence: _____

County of Residence: _____

HEALTH AND DISABILITY INFORMATION

Does the client have a disabling condition?

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

Disability Sub-assessment

Disability Type	Disability Determination				If Yes, to be of long-continued and indefinite duration and substantially impairs ability to live independently?			
	Yes	*No*	*Client doesn't know*	*Client Refused*	*Yes*	*No*	*Client doesn't know*	*Client Refused*
Physical								
Developmental								
Chronic Health Condition								
HIV/AIDS								
Mental Health Problem								
Alcohol Abuse								
Drug Abuse								
Both Alcohol & Drug Abuse								

Notes on Disability: _____

General Health Status

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Client doesn't know
- ☐ Client refused

Dental Health Status

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Client doesn't know
- ☐ Client refused

Mental Health Status

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Client doesn't know
- ☐ Client refused

Pregnant?

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

If Yes, Projected Birth Date: _____

Covered by Health Insurance?

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

HEALTH INSURANCE sub-assessment

Insurance Type	Yes	No
MEDICAID		
MEDICARE		
State Children's Health Insurance Program		
Veteran Administration (VA) Medical Services		
Employer-Provided Health Insurance		
Health Insurance obtained through COBRA		
Private Pay Health Insurance		
State Health Insurance for Adults		
Indian Health Services Program		
Other (Please Specify: _____)		

EDUCATION INFORMATION

Last Grade Completed

- ☐ Less than Grade 5
- ☐ Grades 5-6
- ☐ Grades 7-8
- ☐ Grades 9-11
- ☐ Grade 12/High School Diploma
- ☐ School program doesn't have grade levels
- ☐ GED
- ☐ Some College
- ☐ Associate's Degree
- ☐ Bachelor's Degree
- ☐ Graduate Degree
- ☐ Vocational Certification
- ☐ Client does know
- ☐ Client refused

School Status

- ☐ Attending School Regularly
- ☐ Attending School Irregularly
- ☐ Graduated High School
- ☐ Obtained GED
- ☐ Dropped Out
- ☐ Suspended
- ☐ Expelled
- ☐ Client doesn't know
- ☐ Client refused

EMPLOYMENT INFORMATION

Employed?

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

If Yes, Type of Employment

- ☐ Full-time
- ☐ Part-time
- ☐ Seasonal/sporadic (including day labor)

If No, Why not Employed

- ☐ Looking for work
- ☐ Unable to work
- ☐ Not looking for work

INCOME & NON-CASH BENEFITS

(Youth) Currently receiving income from any source? *(Not Required for Basic Center Projects)*

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

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

(If Other Source) **Specify:** _____

Total Monthly Income $_____

Currently receiving any non-cash benefits?

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

X	Source of Non-Cash Benefit (Monthly)	Amount (If applicable)
	Supplemental Nutrition Assistance Program *(Food Stamps)*	$ .00
	Special Supplemental Nutrition Program for WIC	$ .00
	TANF Child Care Services	$ .00
	TANF Transportation Services	$ .00
	Other TANF Funded Services	$ .00
	Other Source – **Specify**: _____	$ .00

YOUNG PERSON'S CRITICAL ISSUES

Issue	Yes	No
Unemployment *(FAMILY MEMBER)*		
Mental Health Issues (*FAMILY MEMBER*)		
Physical Disability (*FAMILY MEMBER*)		
Alcohol or Substance Abuse (*FAMILY MEMBER*)		
Insufficient Income to Support Youth		
Incarcerated Parent of Youth		

REFERRAL INFORMATION

Referral Source

- ☐ Self-Referral
- ☐ Individual *(Parent/Guardian, Relative, Friend, Foster Parent, Other Individual)*
- ☐ Outreach Project
- ☐ Temporary Shelter
- ☐ Residential Project
- ☐ Hotline
- ☐ Child Welfare/CPS
- ☐ Juvenile Justice
- ☐ Law Enforcement/Police
- ☐ Mental Hospital
- ☐ School
- ☐ Other Organization
- ☐ Client doesn't know
- ☐ Client refused

If Referred by FYSB Outreach Project, Number of times approached by outreach prior to entering the project**:** _____

FUNDER SPECIFIC QUESTIONS

FEDERAL HHS ONLY

Date of BCP Status Determination: _____/_____/_____

Youth Eligible for RHY Services

- ☐ Yes
- ☐ No

If yes, runaway youth?:

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

If no, reason why services are not funded by BCP grant:

- ☐ Out of age range
- ☐ Ward of the State – Immediate Reunification
- ☐ Ward of the Criminal Justice System – Immediate Reunification
- ☐ Other

STATE DHS HYR ONLY

DHS-956 Referral Form Received

☐ Yes ☐ No ☐ N/A

HUD/ESG ONLY (Michigan Specific Questions)

Connection With SOAR?

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

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_____

McKinney-Vento (Optional)

McKinney-Vento

☐ Yes
☐ No

Unaccompanied Youth

☐ Yes
☐ No

REMEMBER TO COMPLETE APPROPRIATE MATRIX

CONTACT INFORMATION

Contact Type: _____

Contact Name: _____

Contact Address: _____

Contact Phone: _____

Contact Email: _____

Contact Type: _____

Contact Name: _____

Contact Address: _____

Contact Phone: _____

Contact Email: _____