

NC HMIS Youth Basic Intake Form

Basic Center Prevention, TLP, MGH

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

- | | | |
|--|--|--|
| <input type="checkbox"/> American Indian or Alaskan Native | <input type="checkbox"/> Native Hawaiian or other Pacific Islander | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Asian | <input type="checkbox"/> White | <input type="checkbox"/> Client refused |
| <input type="checkbox"/> Black or African American | | |

Ethnicity

- | | |
|--|--|
| <input type="checkbox"/> Non-Hispanic/Non-Latino | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> Client refused |

Sexual Orientation

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Heterosexual | <input type="checkbox"/> Bisexual | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Gay | <input type="checkbox"/> Questioning/Unsure | <input type="checkbox"/> Client refused |
| <input type="checkbox"/> Lesbian | | |

Parental Engagement in Care

- | | | |
|---|-----------------------------------|----------------------------------|
| <input type="checkbox"/> No involvement | <input type="checkbox"/> Moderate | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Limited | <input type="checkbox"/> Strong | |

FOSTER CARE INFORMATION

Formerly a Ward of Child Welfare/Foster Care Agency

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

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

- | | |
|---|---|
| <input type="checkbox"/> Less than one year | <input type="checkbox"/> 3 to 5 or more years |
| <input type="checkbox"/> 1 to 2 years | |

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

Formerly a Ward of Juvenile Justice System

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

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

- | | |
|---|---|
| <input type="checkbox"/> Less than one year | <input type="checkbox"/> 3 to 5 or more years |
| <input type="checkbox"/> 1 to 2 years | |

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

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?

(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
SECTION I	<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 ongoing 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

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
 Seasonal/sporadic (including day labor)
 Part-time

If No, Why not Employed

- Looking for work
 Not looking for work
 Unable to work

INCOME & NON-CASH BENEFITS

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

- Yes
 Client doesn't know
 No
 Client refused

X	Source of Income (Monthly)	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>)	\$.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 (<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
	Other Source – Specify: _____	\$.00

YOUNG PERSON'S CRITICAL ISSUES

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

REFERRAL INFORMATION

Referral Source

- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Self-Referral <input type="checkbox"/> Individual (<i>Parent/Guardian, Relative, Friend, Foster Parent, Other Individual</i>) <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 | <ul style="list-style-type: none"> <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 |
|--|---|

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

BCP DETERMINATION STATUS

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

CONTACT INFORMATION

Contact Type: _____

Contact Name: _____

Contact Address: _____

Contact Phone: _____

Contact Email: _____

Contact Type: _____

Contact Name: _____

Contact Address: _____

Contact Phone: _____

Contact Email: _____

Contact Type: _____

Contact Name: _____

Contact Address: _____

Contact Phone: _____

Contact Email: _____

Contact Type: _____

Contact Name: _____

Contact Address: _____

Contact Phone: _____

Contact Email: _____

FUNDER SPECIFIC QUESTIONS

REQUIRED FOR HUD FUNDED PROJECTS

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?

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

Overview of domestic violence
