Friendship Mission, Inc.

HMIS
CLIENT ID# _____

AL504 HMIS Intake Form

Date:_____ **Acceptance Date:_____**

1. **Name: First _____ Middle _____ Last _____**
2. **Phone number: _____**
3. **Do you go by any other names? If so, please list here: _____**
4. **Social Security Number: _____ - _____ - _____**
5. **Have you ever served in the military? *(Circle One)* Yes / No**
6. **Do you have a Continuum ID Card? *(Circle One)* Yes / No**

   (If YES, enter Continuum ID: _____)
7. **What is your Date of Birth? _____ / _____ / _____**
8. **What race are you? *(Circle One)***

   Black / White / American Indian or Alaska Native / Asian / Native Hawaiian or Pacific Islander
9. **Do you have Hispanic or Latin heritage? *(Circle One)* Yes / No**
10. **What is your gender? *(Circle One)***

    Male / Female / Transgender Male to Female / Transgender Female to Male / Other
11. **Do you have a disabling condition? *(Circle One)* Yes / No**
12. **Where did you stay last night? _____**
13. **How long have you been staying where you were last night?**

    (Number of) _____Years _____Months _____Days
14. **Are you the Head of Household? (Circle One) Yes / No**
    (If NO, what is your relation to the head of household? _____)
15. **Have you been continuously homeless for one year?**
    (Circle One) **Yes / No**
16. **Number of times you have been homeless in the past three years? _____**

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17. If 4 or more, what is the total number of months you have been homeless in the past three years? _____

18. What is the total number of months that you have continuously been homeless immediately prior to coming to this shelter? _____

18. What type of income do you receive? *(Circle All that Apply AND Enter Amount)*

NONE / Alimony $_____ / Child Support $_____ / Earned Income $_____ / General Assistance (HUD) $_____ / Other (HUD)/ Pension or retirement income from another job $_____ / Private Disability Insurance $_____/ Retirement Income from Social Security $_____ / SSDI $_____ / SSI $_____ TANF $_____/ Unemployment Insurance $_____ / Veteran Non-Service Connected Disability Pension $_____/ Veteran Service Connected Disability Compensation $_____/ Worker's Compensation $_____

19. What type of Non-Cash Benefits do you receive? *(Circle All that Apply AND Enter Amount)*

NONE / Food Stamps $_____ / SCHIP / WIC $_____/TANF Child Care Services $_____/ TANF Transportation Services $_____/ Other TANF-Funded Services $_____/Section 8, Public Housing, or other ongoing rental assistance $_____/ Other Source $_____ and Name of Source _____/ Temporary Rental Assistance$_____

20. What type of Health Insurance do you have? *(Circle All that Apply)*

NONE / MEDICAID / State Children's Health Insurance Program/ Veteran's Administration (VA) Medical Services/ Health Insurance obtained through COBRA/ Private Health Insurance/ State Health Insurance for Adults/ Indian Health Services Program / Other_____

21. Disability Type? *(Circle All that Apply)*

NONE / Alcohol Abuse / Developmental / Drug Abuse / HIV or AIDS / Mental Health / Physical / Chronic Health Condition (heart, diabetes, etc.)

Do you expect your disability to be long term? Yes / No

Are you receiving medical treatment for your disability? Yes / No

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22. Are you a domestic violence victim/survivor? *(Please Circle One)* Yes / No

23. If yes, for domestic violence, when did it occur?

Past 3 months / 3-6 Months Ago / 6-12 Months Ago / More than a Year

<u>Are you currently fleeing</u>? Yes / No

24. Are you currently working? Yes / No

25. If yes, when did you start working? Date _____/_____/_____

26. If you are not working, when is the last time you had a job?
Date_____/_____/_____

Do you take any medication if yes please list: _____

_____

_____

Can you pass a drug test: Yes ___ No ___ if no what will you fail for: _____

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Additional Family Members 18 and under:

Name: _____

Social Security: _____-_____-_____

Date of Birth: Month_____ Day_____ Year_____

Gender: *(Circle One)* Male / Female

Race: _____

Hispanic or Latino heritage: *(Circle One)* Yes / No

Disabled: *(Circle One)* Yes / No

Relationship to Head of Household: _____

Health Insurance: *(Circle One)* Yes / No If Yes, Carrier: _____

Name: _____

Social Security: _____-_____-_____

Date of Birth: Month_____ Day_____ Year_____

Gender: *(Circle One)* Male / Female

Race: _____

Hispanic or Latino heritage: *(Circle One)* Yes / No

Disabled: *(Circle One)* Yes / No

Relationship to Head of Household: _____

Health Insurance: *(Circle One)* Yes / No If Yes, Carrier: _____

Name: _____

Social Security: _____-_____-_____

Date of Birth: Month_____ Day_____ Year_____

Gender: *(Circle One)* Male / Female

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Race: _____

Hispanic or Latino heritage: *(Circle One)* Yes / No

Disabled: *(Circle One)* Yes / No

Relationship to Head of Household: _____

Health Insurance: *(Circle One)* Yes / No If Yes, Carrier: _____

Name: _____

Social Security: _____-_____-_____

Date of Birth: Month_____ Day_____ Year_____

Gender: *(Circle One)* Male / Female

Race: _____

Hispanic or Latino heritage: *(Circle One)* Yes / No

Disabled: *(Circle One)* Yes / No

Relationship to Head of Household: _____

Health Insurance: *(Circle One)* Yes / No If Yes, Carrier: _____

Name: _____

Social Security: _____-_____-_____

Date of Birth: Month_____ Day_____ Year_____

Gender: *(Circle One)* Male / Female

Race: _____

Hispanic or Latino heritage: *(Circle One)* Yes / No

Disabled: *(Circle One)* Yes / No

Relationship to Head of Household: _____

Health Insurance: *(Circle One)* Yes / No If Yes, Carrier: _____

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Program Entry Date (to be completed by staff): _____

:

RELEASE OF INFORMATION (ROI)

Client's Last Name: _____ **First Name:** _____ **MI:** _____

Date of Birth: _____ **Social Security Number:** _____

* The Federal Privacy Act of 1974 requires that you be notified that disclosure of your Social Security number is voluntary under this record-keeping system. This system was authorized pursuant to directives from Congress and the Department of Housing and Urban Development (HUD). The Social Security number is used to verify identity, assure timely delivery of services, prevent duplication of services, and generate accurate required reports to HUD.

The **PromisSE** is a shared, computerized record keeping system that captures information about people experiencing homelessness or near homelessness, including their service needs. Our Agency,_____, is participating in **PromisSE** that collects information on clients served by its member agencies and the services they provide.

I understand that all information gathered about me is personal and private and that I do not have to share information collected in **PromisSE**. It has been explained to me that all information collected will serve for reporting purposes and as a precaution to prevent duplication of services to ineligible individuals and families. I have had an opportunity to ask questions about **PromisSE** and to review the identifying information, which is authorized by this release for the **PromisSE** Member Agencies to share. I also understand that information about non-confidential services provided to me by human service agencies in the CoC may be shared with other participating in **PromisSE** agencies. This Release of Information will remain in effect for 5 (five) years and will expire on _____ unless I make a formal request to this Agency that I no longer wish to participate in **PromisSE**.

- □ **I authorize to share my data**
- □ **I do not authorize to share my data**

The CoC, as **PromisSE** Member Agency, to share my information between all participating **PromisSE** agencies. I authorize the use of a copy of this original to serve as an original for the purposes stated above.

Client's (Head of Household) Printed Name	Other Adult in HH Printed Name
Client's (Head of Household) Signature	Other Adult in HH Signature
Date (mm/dd/yy)	Date (mm/dd/yy)

Based on the above information,

- □ **I authorize to share my dependants' data**
- □ **I do not authorize to share my dependants' data**

The CoC, as **PromisSE** Member Agency, to share my information between all participating **PromisSE** agencies. I authorize the use of a copy of this original to serve as an original for the purposes stated above.

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_____ DOB	_____ Dependent's Name	_____ DOB	_____ Dependent's Name
_____ DOB	_____ Dependent's Name	_____ DOB	_____ Dependent's Name
_____ DOB	_____ Dependent's Name	_____ DOB	_____ Dependent's Name
_____ DOB	_____ Dependent's Name	_____ DOB	_____ Dependent's Name

_____ _____
Legal Guardian's Authorizing Signature Date (mm/dd/yy)