

-Continuum of Care – Basic Data Collection HMIS Form –

- Hope Center for HP and RRH– (2021)



Client ID:	Project Entry Date:	Staff Member Completing Assessment:	
First, Mi., Last Name, Suf:	<input type="checkbox"/> Full Name Reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Data Not Collected <input type="checkbox"/> Client Refused <input type="checkbox"/> Partial Street Name or Code Name Reported		
Social Security Number:	<input type="checkbox"/> Full SSN Reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Partial SSN Reported <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected		
U.S. Military Veteran:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client <input type="checkbox"/> Data Not Refused Collected		
Parish:	Time of Initial Call:		
Date of Birth:	<input type="checkbox"/> Full DOB Reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Partial or Partial Reported <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected		
Race (Choose two if applicable):	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> Asian
	<input type="checkbox"/> Black or African American	<input type="checkbox"/> White	<input type="checkbox"/> Client Refused
	<input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Other	
Ethnicity (Choose One):	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/ Latino <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected		
Gender:	<input type="checkbox"/> Female	<input type="checkbox"/> Male	<input type="checkbox"/> Other
	<input type="checkbox"/> Trans Male (FTM or Female to Male)	<input type="checkbox"/> Trans Female (MTF or Male to Female)	<input type="checkbox"/> Client Refused
	<input type="checkbox"/> Gender Non-Confirming (Not Exclusively male or female)	<input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Client Doesn't Know
Do You Have a Disability of Long Duration:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client <input type="checkbox"/> Data Not Refused Collected		
Relationship to Head of Household:	<input type="checkbox"/> Self (Head of Household)	<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	<input type="checkbox"/> Data Not Completed	

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Client Location: LA - 503

Housing Move – in Date:

Prior Living Situation (Where Client Stayed the night before program)

Homeless Situation	Institutional Situation	Temporary & Permanent Housing Situation
<ul style="list-style-type: none"> <input type="checkbox"/> Place not meant for habitation <input type="checkbox"/> Emergency shelter, incl. hotel/motel paid for w/ES voucher, or RHY- funded Host Home Shelter <input type="checkbox"/> Safe Haven 	<ul style="list-style-type: none"> <input type="checkbox"/> Foster care home or foster care 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"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected 	<ul style="list-style-type: none"> <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Host Home (non – crisis) <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"/> Rental by client, with GPD TIP housing subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons <input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based) <input type="checkbox"/> Rental by client in a public housing unit <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Renter by client, with other ongoing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy

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Length of stay at Prior Living Situation (Homeless Situation)	Length of stay at Prior Living Situation (Institutional Situation)	Length of stay at Prior Living Situation (Transitional and Permanent Situation)
<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 <input type="checkbox"/> Data Not Collected	<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 <input type="checkbox"/> Client Refused	<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 <input type="checkbox"/> Client doesn't know

Approximate date homelessness started:

(Notes Below)

_____ / _____ / _____

Number of times the client has been on the streets or in emergency shelter in the past three years (including today)

- 1 time
 2 times
 3 times
 4 or more times
 Client doesn't know
 Client refused

Total number of months homeless on the street or in emergency shelter in the past three years (including today, which equals 1 month):

- Client doesn't know
 Client refused

Notes: Approx. Date Homelessness Started (Approximations Expected)

- Determining the approximate date homelessness started:
- Have the client look back to the date of the last time the client had a place to sleep that was not on the streets, ES, or SH.
- The look back time would not be broken by a stay of less than 7 consecutive nights in any permanent or temporary housing situation.
- The look back time also would not be broken by an institutional stay of less than 90 days (i.e. jail, substance abuse or mental health treatment facility, hospital, or other similar facility).
- Include any continuous time moving around between the streets, an emergency shelter, or a Safe haven.

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Total Monthly Income: \$ _____ (Income from any source)		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected			
Source of Income	Receiving income from any source?	Amount of income	How often:	Start Date	End Date
Alimony or other spousal support	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Child support	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Earned income	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Pension or retirement income from another job	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Private disability insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Retirement income from social security	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
SSDI	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
SSI	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
TANF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Unemployment insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
VA Non- service connected disability pension	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Worker's compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				

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Non cash benefit from any source:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected
Source of non-cash benefit	Receiving income from any source?			Start Date	End Date
Supplemental Nutritional Assistance Program (Food Stamps)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Special Supplemental Nutrition Program for WIC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
TANF Child Care Services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
TANF Transportation Services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Other TANF Funded Services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				

Covered by health insurance:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected
Source of Health Insurance	Covered			Start Date	End Date
Medicaid	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Medicare	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
State Children's Health	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Veteran's Admin Medical	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Employer Provided Health Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Health Insurance obtained through COBRA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Private pay health insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
State health insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Indian health insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				

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Disability Type	Currently Receiving Services or Treatment	Condition Long Term? (Y/N)	Start Date	Disability Determination (Y/N)	Disability Verification on File (Y/N)	End Date
Alcohol abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client don't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not completed					
Both Alcohol and Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client don't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not completed					
Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client don't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not completed					
Chronic Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client don't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not completed					
Developmental	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client don't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not completed					
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client don't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not completed					
Mental Health	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client don't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not completed					
Physical	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client don't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not completed					

Note on Disability:



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Domestic violence victim/survivor:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected
If Yes for domestic violence victim/survive; when experiences occurred:	<input type="checkbox"/> Within the past 3 months	<input type="checkbox"/> 3-6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> Data Not Collected	
	<input type="checkbox"/> More than 1 year ago	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused		
If Yes for domestic violence/survivor, are you fleeing:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected
Have you ever been placed in foster care:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected

Coordinated Entry Assessment	
Date of Assessment:	End Date:
Assessment Location:	Assessment Type: <input type="checkbox"/> Phone <input type="checkbox"/> Virtual <input type="checkbox"/> In Person
Assessment Level: <input type="checkbox"/> Crisis needs assessment <input type="checkbox"/> Housing needs assessment	Prioritization Status: <input type="checkbox"/> Placed on prioritization list <input type="checkbox"/> Not placed on prioritization list

Connection with SOAR :	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected
Last Grade Completed:	<input type="checkbox"/> Less than Grade 5	<input type="checkbox"/> Grades 5-6	<input type="checkbox"/> Grades 7-8	<input type="checkbox"/> Grades 9-11	<input type="checkbox"/> Grade 12/High school diploma
	<input type="checkbox"/> School program does not have grade levels	<input type="checkbox"/> GED	<input type="checkbox"/> Some College Degree	<input type="checkbox"/> Graduate degree	<input type="checkbox"/> Client doesn't know
				<input type="checkbox"/> Vocational Certificate	<input type="checkbox"/> Client refused
Employed:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected
If yes, Type of employment	<input type="checkbox"/> Full-time	<input type="checkbox"/> Part-time	<input type="checkbox"/> Seasonal/sporadic (including day labor)		<input type="checkbox"/> Data not collected
If no, Why not employed	<input type="checkbox"/> Looking for work	<input type="checkbox"/> Unable to work	<input type="checkbox"/> Not looking for work	<input type="checkbox"/> Data not collected	

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Veteran Information	
Year entered military Service:	Year separated from military service:
World War II: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected	Korean War: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Vietnam War: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected	Persian Gulf War: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Afghanistan: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected	Iraq Freedom: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Iraq Dawn: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected	Other peace – keeping operations or military interventions: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Branch of Military: <input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Navy <input type="checkbox"/> Marines <input type="checkbox"/> Coast Guards <input type="checkbox"/> Reserves <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected	
Discharge Status: <input type="checkbox"/> Honorable <input type="checkbox"/> Bad Conduct <input type="checkbox"/> Dishonorable <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected <input type="checkbox"/> Uncharacterized <input type="checkbox"/> General under honorable condition <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Under other than honorable condition	

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Percentage of AMI:	<input type="checkbox"/> Less than 30% <input type="checkbox"/> 30% to 50% <input type="checkbox"/> Greater than 50%
Client's Residence/ Last Permanent Address	
Client's Street Address/ Apartment Number:	Address Data Quality: <input type="checkbox"/> Full Address reported <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Incomplete or estimated address reported <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Client's City/State/ Zip:	Address Pre, Temp, or Post Disaster? <input type="checkbox"/> Pre-Disaster <input type="checkbox"/> Post Disaster <input type="checkbox"/> Temporary Residence or Shelter
Primary Reason for current living situation:	<input type="checkbox"/> Public school <input type="checkbox"/> Parochial or other private school <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
Do you want help contacting your family: <input type="checkbox"/> Birth certificates <input type="checkbox"/> Immunization requirements <input type="checkbox"/> Transportation <input type="checkbox"/> Physical examination records <input type="checkbox"/> Residency requirement <input type="checkbox"/> Other <input type="checkbox"/> Lack of available preschool programs <input type="checkbox"/> Legal guardianship requirements <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	
Residence Street Name/Parish of Residence/Home Phone Number/Alternate Number:	
Reason for Leaving this Residence: <input type="checkbox"/> Asked to leave by family <input type="checkbox"/> Building condemned <input type="checkbox"/> Domestic violence <input type="checkbox"/> Drug use by others <input type="checkbox"/> Entered mental health res prog. <input type="checkbox"/> Entered substance abuse prog. <input type="checkbox"/> Evicted <input type="checkbox"/> Evicted for other reasons <input type="checkbox"/> Evicted for overdue rent <input type="checkbox"/> Family/Friend conflict <input type="checkbox"/> Family/Friend evicted <input type="checkbox"/> Fire <input type="checkbox"/> Loss of job <input type="checkbox"/> Moved <input type="checkbox"/> Moved into transitional housing <input type="checkbox"/> Moved to new residence <input type="checkbox"/> Moved to permanent housing <input type="checkbox"/> Moved with friends/family <input type="checkbox"/> Other <input type="checkbox"/> Overcrowding <input type="checkbox"/> Ran away <input type="checkbox"/> Received emergency housing <input type="checkbox"/> Residence destroyed/ razed <input type="checkbox"/> Unable to pay rent <input type="checkbox"/> Unknown	
Landlords' Name/Address/City/State/ Phone:	
Start Date:	End Date:

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VAMC Station Number:	
Referred by Coordinated Entry or a homeless assistance provider to prevent the household from entering an emergency shelter or transitional housing or from staying in a place not for human habitation:	<input type="checkbox"/> Yes <input type="checkbox"/> No (0 Points)
Current housing loss expected within...	<input type="checkbox"/> 0-6 days <input type="checkbox"/> 7-13 days <input type="checkbox"/> 14-21 days <input type="checkbox"/> More than 21 days (0 points)
Current household income is \$0:	<input type="checkbox"/> Yes <input type="checkbox"/> No (0 Points)
Sudden and significant decrease in cash income (employment and/or cash benefits) AND/OR unavoidable increase in non-discretionary expenses (e.g., rent or medical expenses) in the past 6 months:	<input type="checkbox"/> Yes <input type="checkbox"/> No (0 Points)
Major change in household composition (e.g. death of family member, separation/divorce from adult partner, birth of new child) in the past 12 months:	<input type="checkbox"/> Yes <input type="checkbox"/> No (0 Points)
Rental evictions within the past 7 years:	<input type="checkbox"/> 4 or more prior rental evictions <input type="checkbox"/> 2-3prior rental evictions <input type="checkbox"/> 1 prior rental eviction <input type="checkbox"/> No prior rental evictions (0 points)
Currently at risk of losing a tenant-based housing subsidy or housing in a subsidized building or unit:	<input type="checkbox"/> Yes <input type="checkbox"/> No (0 Points)
History of literal homelessness (street/shelter/transitional housing):	<input type="checkbox"/> 4 or more times or total of at least 12 months in past three years <input type="checkbox"/> 2-3 times in past three years <input type="checkbox"/> 1 time in past three years <input type="checkbox"/> None (0 points)
Head of household with disabling condition (physical health, mental health, substance use) that directly affects ability to secure/maintain housing:	<input type="checkbox"/> Yes <input type="checkbox"/> No (0 Points)
Criminal record for arson, drug dealing or manufacture, or felony offense against persons or property:	<input type="checkbox"/> Yes <input type="checkbox"/> No (0 Points)
Registered sex offender:	<input type="checkbox"/> Yes <input type="checkbox"/> No (0 Points)

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At least one dependent child under age 6:	<input type="checkbox"/> Yes	<input type="checkbox"/> No (0 Points)
Single parent with minor child(ren):	<input type="checkbox"/> Yes	<input type="checkbox"/> No (0 Points)
Household size of 5 or more requiring at least 3 bedrooms (due to age/gender mix):	<input type="checkbox"/> Yes	<input type="checkbox"/> No (0 Points)
Any veteran in household served in Iraq or Afghanistan:	<input type="checkbox"/> Yes	<input type="checkbox"/> No (0 Points)
Female Veteran:	<input type="checkbox"/> Yes	<input type="checkbox"/> No (0 Points)
HP applicant total points (integer)		
Grantee targeting threshold score (integer)		

Coordinated Entry Event :

Access Events

- Referral to Prevention Assistance project
- Problem Solving/Diversion/Rapid Resolution intervention or service
- Referral to scheduled Coordinated Entry Crisis Needs Assessment
- Referral to scheduled Coordinated Entry Housing Needs Assessment

Referral Events

- Referral to post-placement/follow-up case management
- Referral to Street Outreach project or services
- Referral to Housing Navigation project or services
- Referral to Non-continuum services: Ineligible for continuum services
- Referral to Non-continuum services: No availability in continuum services
- Referral to Emergency Shelter bed opening
- Referral to Transitional Housing bed/unit opening
- Referral to Joint TH-RRH project/unit/resource opening
- Referral to RRH project resource opening
- Referral to PSH project resource opening
- Referral to Other PH project/unit/resource opening

If 'Event' answer was 'Problem Solving/Diversion/Rapid Resolution intervention or service result', please answer the following question:

Problem Solving/ Diversion/ Rapid Resolution intervention or service result – Client housed/re-housed in a safe alternative:

- Yes No

If 'Event' answer was 'Referral to post-placement/follow-up case management result', please answer the following question:

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Referral to post- placement/follow-up case management result- Enrolled in Aftercare project:	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If 'Event' answer was 'Referral to an ES, TH, Joint TH-RRH, RRH, PSH or Other PH opening', please answer the following question:

Location of Crisis housing or Permanent Housing Referral:

If 'Event' answer was 'Referral to an ES, TH, Joint TH-RRH, RRH, PSH or Other PH opening', please answer the following question:

Referral Result:	<input type="checkbox"/> Successful referral: client accepted <input type="checkbox"/> Unsuccessful referral: client rejected <input type="checkbox"/> Unsuccessful referral: provider rejected
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If 'Event' answer was 'Referral to an ES, TH, Joint TH-RRH, RRH, PSH or Other PH opening', please answer the following question:

Data of Result:	
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Notes: