

-Continuum of Care – RHY Basic Data Collection HMIS

Form – SO, ES, TH and HP – (2021)



Client ID:	Project Entry Date:		
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		
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 Refused <input type="checkbox"/> Data Not 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	

Client Location: LA - 503

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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

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)
<ul style="list-style-type: none"> <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights 	<ul style="list-style-type: none"> <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights 	<ul style="list-style-type: none"> <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights

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<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 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 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
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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				

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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				

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
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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
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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		

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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		

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					

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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					
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Note on Disability:

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

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Current Living Situation

Required by Street Outreach, Coordinated Entry and Emergency Shelter

Required when a Project Start Date is entered, Date of Engagement is recorded. Data is recorded for Head of Household on each occurrence/update.

Information Date: _____/_____/_____

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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Living Situation verified by: LA-503					
Is client going to have to leave their current living situation within 14 days?	<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' Is client going to have to leave their current living situation within 14 days? Answer the following questions.					
Has a subsequent residence been identified?	<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
Does individual or family have resources or support networks to obtain other permanent housing?	<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
Has the client had a lease or ownership interest in a permanent housing unit in the last 60 days?	<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
Has the client moved 2 or more times in the last 60 days?	<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

Date of Engagement

____/____/____

Referral Source

- | | | |
|---|---|---|
| <input type="checkbox"/> Self Referral | <input type="checkbox"/> Individual | <input type="checkbox"/> Child Welfare/CPS |
| <input type="checkbox"/> Outreach Project | <input type="checkbox"/> Temporary Shelter | <input type="checkbox"/> Juvenile Justice |
| <input type="checkbox"/> Residential Project | <input type="checkbox"/> Hotline | <input type="checkbox"/> Mental Hospital |
| <input type="checkbox"/> Law Enforcement/Police | <input type="checkbox"/> School | <input type="checkbox"/> Other Organization |
| <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Data Not Collected | <input type="checkbox"/> Client Refused |

Youth Eligible for RHY Services

- Yes No

If No for "Youth Eligible for RHY Services", Reason why services are not funded by BCP Grant

- | | |
|---|--|
| <input type="checkbox"/> Out of Age Range | <input type="checkbox"/> Ward of the State – Immediate reunification |
| <input type="checkbox"/> Ward of the Criminal Justice System- Immediate reunification | <input type="checkbox"/> Other |

If Yes for "Youth Eligible for RHY Services", Runaway youth

- Yes No Client doesn't know Client refused Data not collected

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Sexual Orientation

- Heterosexual Gay Client Doesn't Know
- Lesbian Bisexual Client Refused
- Questioning / Unsure Other Data Not Collected

If Other, please describe

Last Grade Completed

- Less Than Grade Five Grades 5-6 Grades 7-8
- Grades 9-11 Grade 12/ High School Diplomas School Program does not have grade levels
- GED Some College Associate Degree
- Bachelor's Degree Graduate Degree Vocational Certificate
- Client doesn't know Client Refused Data Not Collected

School Status

- Attending school regularly Attending school irregularly Graduated high school
- Obtained GED Dropped Out Suspended
- Expelled
- Client doesn't know Client Refused Data Not Collected

Employed?

- Yes No Client doesn't know Client refused Data not collected

If Yes, Type of Employment

- Full-Time Part-Time
- Seasonal/Sporadic (Including Day Labor) Data not collected

If No, why not Employed

- Looking for work Unable to work
- Not looking for work Data not collected

General Health Status

- Excellent Very Good Good
- Fair Poor Client doesn't know
- Client refused Data not collected

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Dental Health Status	<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	
	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Client doesn't know	
	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected		
Mental Health Status	<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	
	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Client doesn't know	
	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected		
Pregnant?	<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, Projected Birth Date				
Formerly a Ward of Child Welfare/Foster Care Agency Number of Years	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
	<input type="checkbox"/> Less than a year	<input type="checkbox"/> 1 to 2 years	<input type="checkbox"/> 3 to 5 more years	<input type="checkbox"/> Data not collected
If Less than one year, Number of Months				
Formerly a Ward of Juvenile Justice System Number of Years	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
	<input type="checkbox"/> Less than a year	<input type="checkbox"/> 1 to 2 years	<input type="checkbox"/> 3 to 5 more years	<input type="checkbox"/> Data not collected
If Less than one year, Number of Months				
Family Critical Issues				
Unemployment – Family Member	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected	
Mental Health Issues – Family Member	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected	
Physical Disability – Family Member	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected	
Alcohol or Substance Abuse – Family Member	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected	
Insufficient Income to support youth – Family member	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected	
Incarcerated Parent of Youth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected	

Coordinated Entry Assessment

Date of Event:

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Notes:

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

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

Referral to post- placement/follow-up case management result- Enrolled in Aftercare project:

Yes No

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 (below):

Referral Result:

Successful referral: client accepted Unsuccessful referral: client rejected Unsuccessful referral: provider rejected

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:

Notes: