


-Continuum of Care – Basic Data Collection HMIS Form –

- ES, CO, SH, CE – (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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When Did you originally move to the New Orleans area:	<input type="checkbox"/> Five Years or More or Native of New Orleans	<input type="checkbox"/> In the Past Three Months	<input type="checkbox"/> More Than Three Months but less than Five Years
Zip Code of Last Permanent Address or City:			

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

Homeless Situation	Institutional Situation	Temporary & Permanent Housing Situation
<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	<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	<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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If place not meant for habitation, what type:	<input type="checkbox"/> Street, parks, sidewalks, camp	<input type="checkbox"/> Vacant or Abandoned building															
	<input type="checkbox"/> Motor Vehicle	<input type="checkbox"/> Other place not intended for human habitation															
	<input type="checkbox"/> Bus or train section	<input type="checkbox"/> Shelters															
In the last 90 days, were you released from a hospital, jail, mental institution:	<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																
Are you more comfortable staying on the street versus a shelter: <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, Why: <table border="1"> <tr> <td data-bbox="602 726 976 766"> <input type="checkbox"/> Previously denied access </td> <td data-bbox="976 726 1502 766"> <input type="checkbox"/> Don't feel safe in shelter </td> </tr> <tr> <td data-bbox="602 766 976 871"> <input type="checkbox"/> Too many restrictions/barriers in the shelter </td> <td data-bbox="976 766 1502 871"> <input type="checkbox"/> Can't afford the cost to stay <input type="checkbox"/> Ineligible </td> </tr> <tr> <td data-bbox="602 871 976 911"> <input type="checkbox"/> Bad experience </td> <td data-bbox="976 871 1502 911"> <input type="checkbox"/> Other </td> </tr> </table>		<input type="checkbox"/> Previously denied access	<input type="checkbox"/> Don't feel safe in shelter	<input type="checkbox"/> Too many restrictions/barriers in the shelter	<input type="checkbox"/> Can't afford the cost to stay <input type="checkbox"/> Ineligible	<input type="checkbox"/> Bad experience	<input type="checkbox"/> Other									
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Primary reason for being homeless:	<table border="1"> <tr> <td data-bbox="602 911 927 982"> <input type="checkbox"/> Addiction/Substance Abuse </td> <td data-bbox="927 911 1187 982"> <input type="checkbox"/> By Choice </td> <td data-bbox="1187 911 1502 982"> <input type="checkbox"/> Domestic Violence </td> </tr> <tr> <td data-bbox="602 982 927 1054"> <input type="checkbox"/> Eviction/Foreclosure due to Covid-19 </td> <td data-bbox="927 982 1187 1054"> <input type="checkbox"/> Family Conflict </td> <td data-bbox="1187 982 1502 1054"> <input type="checkbox"/> Jail/Prison </td> </tr> <tr> <td data-bbox="602 1054 927 1125"> <input type="checkbox"/> Loss of income due to Covid-19 </td> <td data-bbox="927 1054 1187 1125"> <input type="checkbox"/> Loss of job/unemployment </td> <td data-bbox="1187 1054 1502 1125"> <input type="checkbox"/> Low income </td> </tr> <tr> <td data-bbox="602 1125 927 1176"> <input type="checkbox"/> Mental health issue </td> <td data-bbox="927 1125 1187 1176"> <input type="checkbox"/> Natural Disaster </td> <td data-bbox="1187 1125 1502 1176"> <input type="checkbox"/> Other </td> </tr> <tr> <td data-bbox="602 1176 927 1289"> <input type="checkbox"/> Not allowed to stay on family member's lease or voucher </td> <td data-bbox="927 1176 1187 1289"> <input type="checkbox"/> Physical disability </td> <td data-bbox="1187 1176 1502 1289"> <input type="checkbox"/> Underemployment </td> </tr> </table>		<input type="checkbox"/> Addiction/Substance Abuse	<input type="checkbox"/> By Choice	<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Eviction/Foreclosure due to Covid-19	<input type="checkbox"/> Family Conflict	<input type="checkbox"/> Jail/Prison	<input type="checkbox"/> Loss of income due to Covid-19	<input type="checkbox"/> Loss of job/unemployment	<input type="checkbox"/> Low income	<input type="checkbox"/> Mental health issue	<input type="checkbox"/> Natural Disaster	<input type="checkbox"/> Other	<input type="checkbox"/> Not allowed to stay on family member's lease or voucher	<input type="checkbox"/> Physical disability	<input type="checkbox"/> Underemployment
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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

Street Outreach, Coordinated Entry and Emergency Shelter - BEYOND THIS POINT

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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

____/____/____

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Coordinated Entry Event:

Access Events	Referral Events
<input type="checkbox"/> Referral to Prevention Assistance project <input type="checkbox"/> Problem Solving/Diversion/Rapid Resolution intervention or service <input type="checkbox"/> Referral to scheduled Coordinated Entry Crisis Needs Assessment <input type="checkbox"/> Referral to scheduled Coordinated Entry Housing Needs Assessment	<input type="checkbox"/> Referral to post-placement/follow-up case management <input type="checkbox"/> Referral to Street Outreach project or services <input type="checkbox"/> Referral to Housing Navigation project or services <input type="checkbox"/> Referral to Non-continuum services: Ineligible for continuum services <input type="checkbox"/> Referral to Non-continuum services: No availability in continuum services <input type="checkbox"/> Referral to Emergency Shelter bed opening <input type="checkbox"/> Referral to Transitional Housing bed/unit opening <input type="checkbox"/> Referral to Joint TH-RRH project/unit/resource opening <input type="checkbox"/> Referral to RRH project resource opening <input type="checkbox"/> Referral to PSH project resource opening <input type="checkbox"/> 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:	<input type="checkbox"/> Yes <input type="checkbox"/> No
---	--

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:	<input type="checkbox"/> Yes <input type="checkbox"/> 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):

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Referral Result:	<input type="checkbox"/> Successful referral: client accepted	<input type="checkbox"/> Unsuccessful referral: client rejected	<input type="checkbox"/> 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: