

-Continuum of Care – Basic Data Collection HMIS Form –

- PH, RRH, Other – (2021)



|   |   |  |  |
|---|---|--|--|
| <b>Client ID:</b>                                 | <b>Project Entry Date:</b>  |  |  |
| <b>First, Mi., Last Name, Suf:</b>                | <input type="checkbox"/> Full Name Reported <input type="checkbox"/> Client Doesn't Know<br><input type="checkbox"/> Data Not Collected <input type="checkbox"/> Client Refused<br><br><input type="checkbox"/> Partial Street Name or Code Name Reported |  |  |
| <b>Social Security Number:</b>                    | <input type="checkbox"/> Full SSN Reported <input type="checkbox"/> Client Doesn't Know<br><input type="checkbox"/> Partial SSN Reported <input type="checkbox"/> Client Refused<br><input type="checkbox"/> Data Not Collected                           |  |  |
| <b>U.S. Military Veteran:</b>                     | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client <input type="checkbox"/> Data Not<br><span style="float: right;">Refused   Collected</span>                         |  |  |
| <b>Date of Birth:</b>                             | <input type="checkbox"/> Full DOB Reported <input type="checkbox"/> Client Doesn't Know<br><input type="checkbox"/> Partial or Partial Reported <input type="checkbox"/> Client Refused<br><input type="checkbox"/> Data Not Collected                    |  |  |
| <b>Race (Choose two if applicable):</b>           | <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   |  |
| <b>Ethnicity (Choose One):</b>                    | <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/ Latino<br><input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused<br><input type="checkbox"/> Data Not Collected                             |  |  |
| <b>Gender:</b>                                    | <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 |
| <b>Do You Have a Disability of Long Duration:</b> | <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   |  |  |
| <b>Relationship to Head of Household:</b>         | <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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|  |  |   |  |
|--|--|---|--|
| <b>When Did you originally move to the New Orleans area:</b> | <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 |
| <b>Zip Code of Last Permanent Address or City:</b>           |  |   |  |

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

| Homeless Situation  | Institutional Situation   | Temporary & Permanent Housing Situation  |
|---|---|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Place not meant for habitation</li> <li><input type="checkbox"/> Emergency shelter, incl. hotel/motel paid for w/ES voucher, or RHY- funded Host Home Shelter</li> <li><input type="checkbox"/> Safe Haven</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Foster care home or foster care group home</li> <li><input type="checkbox"/> Hospital or other residential non-psychiatric medical facility</li> <li><input type="checkbox"/> Jail, prison, or juvenile detention facility</li> <li><input type="checkbox"/> Long-term care facility or nursing home</li> <li><input type="checkbox"/> Psychiatric hospital or other psychiatric facility</li> <li><input type="checkbox"/> Substance abuse treatment facility or detox center</li> <br/> <li><input type="checkbox"/> Client Doesn't Know</li> <li><input type="checkbox"/> Client Refused</li> <li><input type="checkbox"/> Data Not Collected</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Residential project or halfway house with no homeless criteria</li> <li><input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher</li> <li><input type="checkbox"/> Transitional housing for homeless persons (including homeless youth)</li> <li><input type="checkbox"/> Host Home (non – crisis)</li> <li><input type="checkbox"/> Staying or living in a family member's room, apartment or house</li> <li><input type="checkbox"/> Staying or living in a friend's room, apartment or house</li> <li><input type="checkbox"/> Rental by client, with GPD TIP housing subsidy</li> <li><input type="checkbox"/> Rental by client, with VASH housing subsidy</li> <li><input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons</li> <li><input type="checkbox"/> Rental by client, with RRH or equivalent subsidy</li> <li><input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based)</li> <li><input type="checkbox"/> Rental by client in a public housing unit</li> <li><input type="checkbox"/> Rental by client, no ongoing housing subsidy</li> <li><input type="checkbox"/> Renter by client, with other ongoing subsidy</li> <li><input type="checkbox"/> Owned by client, no ongoing housing subsidy</li> <li><input type="checkbox"/> Owned by client, with ongoing housing subsidy</li> </ul> |

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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<br><input type="checkbox"/> Two to six nights<br><input type="checkbox"/> One week or more, but less than one month<br><input type="checkbox"/> One month or more, but less than 90 days<br><input type="checkbox"/> 90 days or more but less than one year<br><input type="checkbox"/> One year or longer<br><input type="checkbox"/> Data Not Collected | <input type="checkbox"/> One night or less<br><input type="checkbox"/> Two to six nights<br><input type="checkbox"/> One week or more, but less than one month<br><input type="checkbox"/> One month or more, but less than 90 days<br><input type="checkbox"/> 90 days or more, but less than one year<br><input type="checkbox"/> One year or longer<br><input type="checkbox"/> Client Refused | <input type="checkbox"/> One night or less<br><input type="checkbox"/> Two to six nights<br><input type="checkbox"/> One week or more, but less than one month<br><input type="checkbox"/> One month or more, but less than 90 days<br><input type="checkbox"/> 90 days or more, but less than one year<br><input type="checkbox"/> One year or longer<br><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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|  |   |  |
|--|---|--|
| <b>If place not meant for habitation, what type:</b>   | <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  |
| <b>In the last 90 days, were you released from a hospital, jail, mental institution:</b>   | <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   |  |
| <b>Are you more comfortable staying on the street versus a shelter:</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused<br><input type="checkbox"/> Data not collected | <b>If yes, Why:</b>   |  |
|  | <input type="checkbox"/> Previously denied access<br><input type="checkbox"/> Too many restrictions/barriers in the shelter<br><input type="checkbox"/> Bad experience  | <input type="checkbox"/> Don't feel safe in shelter<br><input type="checkbox"/> Can't afford the cost to stay<br><input type="checkbox"/> Ineligible<br><input type="checkbox"/> Other |
| <b>Primary reason for being homeless:</b>  | <input type="checkbox"/> Addiction/Substance Abuse <input type="checkbox"/> By Choice <input type="checkbox"/> Domestic Violence<br><input type="checkbox"/> Eviction/Foreclosure due to Covid-19 <input type="checkbox"/> Family Conflict <input type="checkbox"/> Jail/Prison<br><input type="checkbox"/> Loss of income due to Covid-19 <input type="checkbox"/> Loss of job/unemployment <input type="checkbox"/> Low income<br><input type="checkbox"/> Mental health issue <input type="checkbox"/> Natural Disaster <input type="checkbox"/> Other<br><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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| <b>Total Monthly Income:</b><br>\$ _____<br>(Income from any source) |   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client<br>doesn't know <input type="checkbox"/> Client<br>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<br><input type="checkbox"/> Data Not Completed |   |            |            |          |
| Child support  | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Data Not Completed |   |            |            |          |
| Earned income  | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Data Not Completed |   |            |            |          |
| Other  | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Data Not Completed |   |            |            |          |
| Pension or retirement income from another job                        | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Data Not Completed |   |            |            |          |
| Private disability insurance   | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Data Not Completed |   |            |            |          |
| Retirement income from social security                               | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Data Not Completed |   |            |            |          |
| SSDI   | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Data Not Completed |   |            |            |          |
| SSI  | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Data Not Completed |   |            |            |          |
| TANF   | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Data Not Completed |   |            |            |          |
| Unemployment insurance   | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Data Not Completed |   |            |            |          |
| VA Non- service connected disability pension                         | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Data Not Completed |   |            |            |          |

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|                              |   |  |  |  |  |
|------------------------------|---|--|--|--|--|
| <b>Worker's compensation</b> | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Data Not Completed |  |  |  |  |
|------------------------------|---|--|--|--|--|

|  |   |
|--|---|
| <b>Non cash benefit from any source:</b> | <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 |
|--|---|------------|----------|
| <b>Supplemental Nutritional Assistance Program (Food Stamps)</b> | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Data Not Completed |            |          |
| <b>Special Supplemental Nutrition Program for WIC</b>            | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Data Not Completed |            |          |
| <b>TANF Child Care Services</b>                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Data Not Completed |            |          |
| <b>TANF Transportation Services</b>                              | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Data Not Completed |            |          |
| <b>Other TANF Funded Services</b>                                | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Data Not Completed |            |          |
| <b>Other</b>   | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><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 |
| <b>Medicaid</b>                                | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed  |            |          |
| <b>Medicare</b>                                | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed  |            |          |
| <b>State Children's Health</b>                 | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed  |            |          |
| <b>Veteran's Admin Medical</b>                 | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed  |            |          |
| <b>Employer Provided Health Insurance</b>      | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed  |            |          |
| <b>Health Insurance obtained through COBRA</b> | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed  |            |          |
| <b>Private pay health insurance</b>            | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed  |            |          |
| <b>State health insurance</b>                  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed  |            |          |

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|                                |  |  |  |
|--------------------------------|--|--|--|
| <b>Indian health insurance</b> | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed |  |  |
| <b>Other</b>                   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed |  |  |

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

**Note on Disability:**

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|  |   |  |  |   |   |
|--|---|--|--|---|---|
| <b>Domestic violence victim/survivor:</b>                                      | <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 |
| <b>If Yes for domestic violence victim/survive; when experiences occurred:</b> | <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 |   |
| <b>If Yes for domestic violence/survivor, are you fleeing:</b>                 | <input type="checkbox"/> More than 1 year ago     | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Client refused      |   |   |
| <b>Have you ever been placed in foster care:</b>                               | <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 |

**PSH\* Must Add Referral Result & Date of Result - BEYOND THIS POINT**

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

Notes:



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