

# -Continuum of Care – Basic Update

## Data Collection HMIS Form — (2021)



<b>Client ID:</b>	<b>Review Date:</b>
<b>First, Mi., Last Name, Suf:</b>	
<b>Housing Move In Date:</b>	<b>Client Location: LA-503</b>

**Notes:** Please make sure to end date any old monthly income, non-cash benefit, disability, health insurance, or coordinated entry event before adding new source and date (Beyond This Point). Neglecting to end date old information, will impact your data negatively.

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<b>Total Monthly Income:</b> \$ _____ (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
<b>Alimony or other spousal support</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
<b>Child support</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
<b>Earned income</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>Pension or retirement income from another job</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
<b>Private disability insurance</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
<b>Retirement income from social security</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
<b>SSDI</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
<b>SSI</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
<b>TANF</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
<b>Unemployment insurance</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
<b>VA Non- service connected disability pension</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
<b>Worker's compensation</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				

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<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 <input type="checkbox"/> Data Not Completed				
<b>Special Supplemental Nutrition Program for WIC</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
<b>TANF Child Care Services</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
<b>TANF Transportation Services</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
<b>Other TANF Funded Services</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>Covered by health insurance:</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 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				
<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				

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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
<b>Alcohol abuse</b>	<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					
<b>Both Alcohol and Drug Abuse</b>	<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					
<b>Drug Abuse</b>	<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					
<b>Chronic Health Condition</b>	<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					
<b>Developmental</b>	<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					
<b>HIV/AIDS</b>	<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					
<b>Mental Health</b>	<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					
<b>Physical</b>	<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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<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"/> More than 1 year ago	<input type="checkbox"/> 3-6 months <input type="checkbox"/> Client doesn't know	<input type="checkbox"/> 6-12 months <input type="checkbox"/> Client refused	<input type="checkbox"/> Data Not Collected
<b>If Yes for domestic violence/survivor, are you fleeing:</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>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

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

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## Data Collection HMIS Form — (2021)



### 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
<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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<b>Living Situation verified by: LA-503</b>	
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**

\_\_\_\_/\_\_\_\_/\_\_\_\_

**Coordinated Entry Assessment**

**Date of Event:**

**Notes:**

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<b>Coordinated Entry Event:</b>	
<b>Access Events</b>	<b>Referral Events</b>
<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
<b>If 'Event' answer was 'Problem Solving/Diversion/Rapid Resolution intervention or service result', please answer the following question:</b>	
<b>Problem Solving/ Diversion/ Rapid Resolution intervention or service result – Client housed/re-housed in a safe alternative:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If 'Event' answer was 'Referral to post-placement/follow-up case management result', please answer the following question:</b>	
<b>Referral to post- placement/follow-up case management result- Enrolled in Aftercare project:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<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>Location of Crisis housing or Permanent Housing Referral:</b>	
<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>	



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<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:**