



Homeless Alliance of WNY HMIS Data Intake Template

FY24 – TH, RRH, PSH, SSO, HP, & CE Projects: Head of Household

1. Intake Information

Intake Date ____/____/____ MM DD YYYY		Intake Staff Name _____	
Household Type <input type="checkbox"/> Single	Household ID (HMIS Assigned): _____ If household type is anything other than "Single" an intake assessment must be completed for each household member.		
	<input type="checkbox"/> Couple with no children	<input type="checkbox"/> Male Single Parent	<input type="checkbox"/> Grandparent(s) and Child
	<input type="checkbox"/> Two Parent Family	<input type="checkbox"/> Foster Parent(s)	<input type="checkbox"/> Other
	<input type="checkbox"/> Female Single Parent	<input type="checkbox"/> Non-Custodial Caregiver(s)	

2. Primary Client/ Head of Household (HOH) Information

Name (First, Middle, Last, Suffix) _____			
Alias/AKA _____		Client ID (HMIS Assigned) _____	
SSN ____-____-____ <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	Date of Birth ____/____/____ <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer		
Race and Ethnicity Select as many as are applicable: <input type="checkbox"/> American Indian, Alaska Native or Indigenous <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black, African American, or African <input type="checkbox"/> Hispanic/Latina/e/o <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer Additional Race and Ethnicity Detail: _____	Gender Select as many as are applicable: <input type="checkbox"/> Woman (Girl, if child) <input type="checkbox"/> Man (Boy, if child) <input type="checkbox"/> Culturally Specific Identity (e.g., Two-Spirit) <input type="checkbox"/> Transgender <input type="checkbox"/> Non-Binary <input type="checkbox"/> Questioning <input type="checkbox"/> Different Identity Specify: <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer		
Sexual Orientation (Required for all YHDP, all RHY, and CoC-funded PSH projects) <input type="checkbox"/> Heterosexual <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Other Specify: <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	Veteran Status <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer		
Survivor of Domestic Violence <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer		
If Yes, When experience occurred: <input type="checkbox"/> Within the past three months <input type="checkbox"/> 3 to 6 months ago (excluding 6 months exactly) <input type="checkbox"/> 6 to 12 months ago (excluding one year exactly) <input type="checkbox"/> One year ago, or more	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer		
If Yes, Are you currently fleeing? <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer		



3. Prior Living Situation

What was the situation the client was living in immediately prior to project entry?

Complete Parts A and B for all clients

If the length of stay in an institution was less than 90 days OR the length of stay in a temporary, permanent or other housing situation was less than one week (7 nights), complete Part C.

If the client's prior living situation was a homeless situation OR the client answered "Yes" to Part C, complete Part D.

A) Prior Living Situation

Homeless Situations

- Place not meant for habitation (e.g., a vehicle, an abandoned building, or anywhere outside)
- Emergency shelter, including hotel or motel paid for with emergency shelter voucher, Host Home Shelter
- Safe Haven

Institutional Situations

- Foster care home or FC group home
- Hospital or other residential non-psychiatric medical facility
- Jail, prison, or juvenile detention facility
- Long-term care facility or nursing home
- Psychiatric hospital or other psych facility
- Substance abuse treatment facility or detox center

Other

- Client doesn't know

Temporary Housing Situations

- Transitional housing for homeless persons (including youth)
- Residential project or halfway house with no homeless criteria
- Hotel or motel paid for without emergency shelter voucher
- Host Home (non-crisis)
- Staying in a friend's room, apartment, or house
- Staying or living in a family member's room, apartment, or house

Permanent Housing Situations

- Rental by client:
 - No ongoing housing subsidy
 - Ongoing housing subsidy
 - Subsidy Type: _____
- Owned by client:
 - No ongoing housing subsidy
 - Ongoing housing subsidy
 - Subsidy Type: _____
- Client prefers not to answer

B) Length of Stay in Previous Place

- | | |
|--|--|
| <input type="checkbox"/> One night or less | <input type="checkbox"/> 90 days or more, but less than one year |
| <input type="checkbox"/> Two to six nights | <input type="checkbox"/> One year or longer |
| <input type="checkbox"/> One week or more, but less than one month | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> One month or more, but less than 90 days | <input type="checkbox"/> Client prefers not to answer |

C) Break in Time Homeless

- On the night before did you stay on the streets, in a shelter, or a safe haven?
- No
 - Yes

D) Date Client started being homeless on the streets, in a shelter, or safe haven

Determine the date of the last time the client had a place to sleep that was not on the streets, in an emergency shelter, or in a safe haven. As the client looks back, there may be breaks in their stay at these locations.

The breaks are allowed to be included in the look back period to calculate the start date only if:

- The client moved continuously between the streets, shelters, or safe havens. The date would go back as far as the first time they stayed in one of those places; OR
- The break in their time on the streets, shelters, or safe havens was less than 7 nights. The time homeless would not be broken by a stay less than 7 consecutive nights; OR
- The break in their time on the streets, shelters, or safe havens was less than 90 days in any of the places listed as "institutional situations." The time homeless would not be broken by a stay less than 90 consecutive nights.

Approximate date current episode of homelessness started

Regardless of where you stayed last night, number of times you have been on the streets, in ES, or SH in the past three years including today?

- One time
- Two times
- Three times
- Four or more times
- Client doesn't know
- Client prefers not to answer

Total number of months homeless on the street, in ES, or SH in the past three years.

- ____ / ____ / ____
- One month (this time is the first month)
 - 2-12 months (# ____)
 - More than 12 months
 - Client doesn't know
 - Client prefers not to answer



4. Income Information (optional for CE projects)

Monthly Income at Intake	If Yes, indicate the amount of income from each source:	Amount
Does the client have income from any source? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Earned Income (i.e., employment income)	
	<input type="checkbox"/> Unemployment Insurance	
	<input type="checkbox"/> Supplemental Security Income (SSI)	
	<input type="checkbox"/> Social Security Disability Insurance (SSDI)	
	<input type="checkbox"/> VA Non-Service-Connected Disability Pension	
	<input type="checkbox"/> Private disability insurance	
	<input type="checkbox"/> Worker's Compensation	
	<input type="checkbox"/> Temporary Assistance for Needy Families (TANF)	
	<input type="checkbox"/> General Assistance (GA)	
	<input type="checkbox"/> Retirement from Social Security	
	<input type="checkbox"/> Pension or retirement income from a former job	
	<input type="checkbox"/> Child support	
	<input type="checkbox"/> Alimony or other spousal support	
	<input type="checkbox"/> Other source – Specify:	
Total Monthly Income:		\$ _____

5. Non-Cash Benefits Information (optional for CE projects)

Non-Cash Benefits at Intake	If Yes, indicate all sources that apply:
Does the client have non-cash benefits from any source? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) <i>Previously known as Food Stamps</i>
	<input type="checkbox"/> Special Supplemental Nutrition Program Women, Infants, and Children (WIC)
	<input type="checkbox"/> TANF Childcare Services
	<input type="checkbox"/> TANF Transportation Services
	<input type="checkbox"/> Other TANF-funded services
	<input type="checkbox"/> Other source – Specify:

6. Insurance Information (optional for CE projects)

Health Insurance at Intake	If Yes, indicate all sources that apply:
Is the client covered by Health Insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> MEDICAID
	<input type="checkbox"/> MEDICARE
	<input type="checkbox"/> State Children's Health Insurance Program
	<input type="checkbox"/> Veteran's Health Administration (VHA)
	<input type="checkbox"/> Employer-Provided Health Insurance
	<input type="checkbox"/> Health Insurance obtained through COBRA
	<input type="checkbox"/> Private Pay Health Insurance
	<input type="checkbox"/> State Health Insurance for Adults
	<input type="checkbox"/> Indian Health Services Program
	<input type="checkbox"/> Other source - Specify:



7. Disability Information (optional for CE projects)

Disability Information at Intake	If yes, indicate all that apply:	Is the disability expected to be of long, continued, indefinite duration and substantially impairs the client's ability to live independently?
Does the client have a disabling condition? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Physical Disability	<input type="checkbox"/>
	<input type="checkbox"/> Developmental Disability	<input type="checkbox"/>
	<input type="checkbox"/> Chronic Health Condition	<input type="checkbox"/>
	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/>
	<input type="checkbox"/> Mental Health Disorder	<input type="checkbox"/>
	<input type="checkbox"/> Substance Use Disorder	<input type="checkbox"/>

8. Translation Assistance Information

Translation Need	If yes, indicate their preferred language:
Does the client need translation assistance? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	

9. Permanent Housing Move-in Date

Housing Move-In Date	
Enter the date the client's homelessness ended and they moved into permanent housing. Leave blank until move-in has occurred.	_____ / _____ / _____ MM DD YYYY

10. Locally Required Elements (NY-508)

Primary Reason Homeless:	
<input type="checkbox"/> Aged out of foster care	<input type="checkbox"/> Mental Health
<input type="checkbox"/> Asked to leave by landlord	<input type="checkbox"/> Mortgage foreclosure on rental property lived in
<input type="checkbox"/> Court eviction by landlord	<input type="checkbox"/> Mortgage foreclosure of own home
<input type="checkbox"/> Domestic Violence (DV)	<input type="checkbox"/> Problems with building
<input type="checkbox"/> Eviction by primary tenant	<input type="checkbox"/> Problems with landlord
<input type="checkbox"/> Fire or natural disaster	<input type="checkbox"/> Release from institution
<input type="checkbox"/> Health/Safety violation	<input type="checkbox"/> Relocation from out of the NY-508 CoC area
<input type="checkbox"/> Household dispute (not DV)	<input type="checkbox"/> Substance Use
<input type="checkbox"/> Loss of job/income (includes public benefits)	<input type="checkbox"/> Utility shut-off/arrears
<input type="checkbox"/> Medical Condition	<input type="checkbox"/> Violence/Assault (not DV)
Zip Code of Last Permanent Address:	

Signatures

I hereby certify that, to the best of my knowledge, the provided information is true and accurate.

Client Signature: _____ **Date:** ____ / ____ / ____

Intake Worker Signature: _____ **Date:** ____ / ____ / ____