Complete one intake for each adult in family.

***Intake Date**: ____/____/____

Warming Center HMIS Intake Form

*First Name	Middle	*Last Name	Jr/Sr	Nickname/Alias

*Social Security Number	*Birth Date	Age	Self / Child / Spouse or Partner / Other Non-Relative *Relationship to Head of Household

F / M / Transgender / Questioning / Gender other than singularly M or F *Gender	Heterosexual / Gay / Lesbian / Bisexual / Questioning or Unsure *Sexual Orientation

Background Information

***Ethnicity** ❑ Hispanic/Latin(o)(a)(x) ❑ Non-Hispanic/Non-Latin(o)(a)(x) ❑ Client doesn't know ❑ Client refused

***What Race BEST describes you? (circle all that apply)**

[Those of Latin heritage should mark American Indian if their ancestry is from North, South or Central America. Those from the Far East (including India) should mark Asian. Those from the Middle East should mark White.]

- ❑ White
- ❑ Black/African American/African
- ❑ Client doesn't know
- ❑ Client refused
- ❑ Asian or Asian American
- ❑ American Indian/Alaskan Native/Indigenous
- ❑ Native Hawaiian/Pacific islander

Have you ever served in the US Military? Yes / No

If yes, Branch of the Military? (Circle one)

❑ Army ❑ Navy ❑ Airforce ❑ Marines ❑ Coast Guard

Year entered military service: ____________ **Year separated from military service:** ____________

Era (check all that apply):

- ❑ World War II
- ❑ Korean War
- ❑ Vietnam War
- ❑ Persian Gulf War
- ❑ Afghanistan
- ❑ Iraq Freedom
- ❑ Iraq Dawn
- ❑ Other Peace-keeping Operations

Discharge Status:

- ❑ Honorable
- ❑ General under honorable conditions
- ❑ Other than honorable (OTH)
- ❑ Bad Conduct
- ❑ Dishonorable
- ❑ Uncharacterized/Other
- ❑ Client doesn't know
- ❑ Client Refused

❑ Literally homeless	❑ Institutional situation	❑ Transitional & Permanent housing
❑ Place not meant for habitation (vehicle, abandoned bldg, train station/airport, or anywhere outside) ❑ Emergency shelter, including hotel or motel paid for with emergency shelter voucher ❑ Safe haven	❑ Foster care home or foster care 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 psychiatric facility ❑ Substance abuse treatment facility or detox center	❑ Hotel or motel paid for without emergency shelter voucher ❑ Host home (non-crisis) ❑ Transitional housing for homeless persons (including homeless youth) ❑ Owned by client, no ongoing housing subsidy ❑ Owned by client, with ongoing housing subsidy ❑ Permanent housing for formerly homeless persons (other than RRH) ❑ Rental by client, no ongoing housing subsidy ❑ Rental by client, with Housing Choice Voucher (HCV) (tenant or project based) ❑ Rental by client, with VASH housing subsidy ❑ Rental by client, with GPD TIP housing subsidy ❑ Rental by client, with other housing subsidy (including RRH) ❑ Residential project or halfway house with no homeless criteria ❑ Staying or living in a family member's room, apartment or house ❑ Staying or living in a friend's room, apartment or house ❑ Client doesn't know ❑ Client refused ❑ Worker unable to confirm
***Length of living situation prior to entering this program:** ❑ One night or less ❑ Two nights to six nights ❑ One week or more, but less than one month ❑ One month or more, but less than 90 days ❑ 90 Days or more, but less than one year ❑ One year or longer ❑ Client doesn't know ❑ Client refused	***Length of living situation prior to entering this program:** ❑ One night or less ❑ Two nights to six nights ❑ One week or more, but less than one month ❑ One month or more, but less than 90 days ❑ 90 Days or more, but less than one year ❑ One year or longer ❑ Client doesn't know ❑ Client refused	***Length of living situation prior to entering this program:** ❑ One night or less ❑ Two nights to six nights ❑ One week or more, but less than one month ❑ One month or more, but less than 90 days ❑ 90 Days or more, but less than one year ❑ One year or longer ❑ Client doesn't know ❑ Client refused
***Approximate date this episode of homelessness started:** _____ / _____ / _________	***If the length of stay above was less than 90 days, did you enter the institution from the streets, Emergency shelter, or Safe Haven?** ❑ Yes ❑ No ***If yes, approximate date this episode of homelessness started:** ____ / ____ / _____ Note: If homelessness began prior to institution stay, and the institution stay was less than 90 days the stay also counts as time homeless.,	***If the length of stay above was less than 7 nights, did you enter the above housing situation from the streets, Emergency shelter, or Safe Haven?** ❑ Yes ❑ No *** If yes, approximate date this episode of homelessness started:** ___ / ____ / _____ Note: If client stayed in a housed situation for less than 7 days, the stay also counts as time homeless.

*** For shelters & street outreach only:** If client is coming from an institution where they stayed more than 90 days or a housed situation where they stayed more than 7 days, then their start date of homelessness would be today's date (Intake Date): **Intake Date:** _____/_____/_____

***Number of times you have been homeless on the streets/shelter in the PAST THREE YEARS including today:** _____

***Total Number of Months Homeless in the PAST THREE YEARS** [Note: Any single day or part of a month spent homeless should be counted as 1 month. Short breaks are acceptable]: _____ **months**

***City where you last had stable housing** _____ ***City Slept In Last Night:** _____

Is this your first time experiencing homelessness (being without housing)? Yes / No

Total length of time client has been homeless or without housing in lifetime _____ Years and _____Months

Were you released as a result of AB109? Yes / No **Domestic Violence Victim/Survivor?** Yes / No

Are you currently on probation? Yes / No **If Yes, when last occurred?** _____

Are you currently on Parole? Yes / No **Are you currently fleeing?** Yes / No

Employed? ☐ **Yes, If Yes, what type?** ☐ **Full Time** ☐ **Part Time** ☐ **Seasonal (including Day Labor)**

☐ **No, If No, why not?** ☐ **Looking for work** ☐ **Unable to work** ☐ **Not Looking for Work**

Monthly Income

Income from Any Source? ☐ Yes ☐No If yes, write the monthly amounts below

Earned Income	$	SSDI	$	TANF	$
Unemployment Insurance	$	SSI	$	GA	$
Workers Compensation	$	Retirement Income from Social Security	$	Alimony Spousal Support	$
Private Disability Insurance	$	VA Non-Service Connected Disability	$	Child Support	$
VA Service-Connected Disability	$	Pension or Retirement from a Former Job	$	Other (Specify):	$

Non Cash Benefits

Receiving Non Cash Benefits? ☐ Yes ☐ No If yes, check all that apply

☐SNAP Supplemental Nutrition Assistance Program (Food Stamps) ☐TANF Childcare Services ☐Other TANF- Funded Services

☐WIC Special Supplemental Nutrition Program for Women, Infants, & Children ☐TANF Transportation Services ☐Other (Specify): _____

Health Insurance

Covered by Health Insurance? ☐ Yes ☐ No If yes, check all that apply

☐Medicaid ☐VA Medical ☐Private Pay Health Insurance ☐Other Health Insurance

☐Medicare ☐Employer-Provided Health Insurance ☐State Health Insurance for Adults Specify Other:

☐State Children's Health Insurance Program ☐COBRA ☐Indian Health Services Program _____

*Disabilities: Please circle Yes or No for EACH of the following

Physical	Yes / No	**Long Term?:** Yes / No	**Mental health problem**	Yes / No	**Long Term?:** Yes / No
Developmental	Yes / No		**Alcohol abuse**	Yes / No	**Long Term?:** Yes / No
Chronic health condition	Yes / No	**Long Term?:** Yes / No	**Drug abuse**	Yes / No	**Long Term?:** Yes / No
HIV/AIDS	Yes / No		**Both Alcohol and Drug Abuse**	Yes / No	**Long Term?:** Yes / No

Note: Chronic health condition – a diagnosed condition that is more than three months in duration and is either not curable or has residual effects that limit daily living and require adaptation in function or special assistance. Examples include but are not limited to: heart disease, severe asthma, diabetes, arthritis-related conditions, adult onset cognitive impairments (including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive related conditions), severe headache/migraine, cancer, chronic bronchitis, liver condition, stroke, or emphysema.

***Do you have a Disabling Condition? This means: A condition of expected long duration or substantially impairs independence**

❑ Yes ❑ No ❑ Client doesn't know ❑ Client refused

Well-Being - Use the scale provided below. You may also use Client doesn't know (DK) or Client refused(R)

Strongly disagree (0), Somewhat disagree (1), Neither agree or disagree (2) Somewhat agree (3), Strongly agree (4),	Client perceives their life has value and worth _____ Client perceives they have support from others who will listen to problems _____ Client perceives they have a tendency to bounce back after hard times _____
Not at all (0) , Once a month (1) , Several times a month (2), Several times a week (3), At least every day (4)	Client's frequency of feeling nervous, tense, worried, frustrated, or afraid _____
Poor (0) , Fair (1) , Good (2), Very Good (3), Excellent (4)	Client's General Health Status _____

Dependents

***35. Please list information about all dependent children (under 18 years old) entering program**

First and last name	Relationship to HOH	Birth date	SSN #	Gender (M/F)	Ethnicity	Race	Special needs	Health Insurance