



Contra Costa Continuum of Care

Contra Costa Homeless Management Information System

Contra Costa Standard HMIS Intake Form

First Name _____ Middle _____ Last Name _____ *Suffix _____ (Jr/Sr.)

*Social Security No: _____ *Intake Date: _____

Case Manager: _____ *Agency/Program: _____

Case Manager Phone: () Case Manager Email: _____

Note: All information requested below is voluntary, however some questions may be required by specific programs to determine eligibility. If client already has an existing record in HMIS, questions 1 thru 9 may be skipped.

1. Nickname/Alias: _____		2. Maiden name: _____	
*3. Birth Date: _____ Age: _____		<input type="checkbox"/> Full <input type="checkbox"/> Approximate/Partial <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	
*4. Gender:		<input type="checkbox"/> Man (Boy if child) <input type="checkbox"/> Transgender <input type="checkbox"/> Culturally Specific Identity (e.g., Two-Spirit) <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Woman (Girl if child) <input type="checkbox"/> Questioning <input type="checkbox"/> Different Identity: _____ <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Non-Binary	
5. Sexual orientation: <input type="checkbox"/> Straight <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Other: _____ <input type="checkbox"/> Client prefers not to answer			
*6. What race best describes you? (Check all that apply)			
<input type="checkbox"/> White <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black, African-American, or African <input type="checkbox"/> American Indian/Alaskan Native/Indigenous		<input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Hispanic/Latina/e/o <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Additional Race and Ethnicity Detail: _____	
7. What is your primary language(s)? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____			
*8. Do you need translation assistance? Yes / No If yes, preferred language(s)? _____			
*9. Have you ever served in the US Military? Yes / No Year entered service: _____ Year separated from service: _____			
Branch of the Military? <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Air force <input type="checkbox"/> Marines <input type="checkbox"/> Coast Guard <input type="checkbox"/> Space Force			
Theater of Operations (Circle Yes or No for each)		Discharge status (Check one)	
World War II Y / N	Afghanistan Y / N	<input type="checkbox"/> Honorable <input type="checkbox"/> Dishonorable <input type="checkbox"/> General under honorable conditions <input type="checkbox"/> Uncharacterized/Other <input type="checkbox"/> Under other than honorable conditions (OTH) <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Bad conduct <input type="checkbox"/> Client prefers not to answer	
Korean War Y / N	Iraqi Freedom Y / N		
Vietnam War Y / N	Iraq New Dawn Y / N		
Persian Gulf War Y / N	Other Y / N		
10. Client Phone No: _____		11. Email: _____	
12. Identification: _____			
13. What is your current or most recent mailing address? Currently staying there (Y/N)? _____			
Address _____		City _____ State _____ Zip _____	
*14. Relationship to head of household:			
<input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Other relation <input type="checkbox"/> Other: Non-relation member			
15. Who referred you to this program?			
<input type="checkbox"/> 211 Crisis line <input type="checkbox"/> Other Crisis line <input type="checkbox"/> Shelter Hotline <input type="checkbox"/> Mental Health Access line <input type="checkbox"/> Hospital (Non-psychiatric) <input type="checkbox"/> Clinic/Outpatient facility <input type="checkbox"/> Skilled nursing facility <input type="checkbox"/> Residential program		<input type="checkbox"/> CARE/Drop in center <input type="checkbox"/> Benefits worker/Case manager <input type="checkbox"/> VA <input type="checkbox"/> CORE outreach <input type="checkbox"/> Police /Law Enforcement <input type="checkbox"/> Criminal justice system (Non AB109) <input type="checkbox"/> AB109 Probation officer <input type="checkbox"/> SSVF Agency	
		<input type="checkbox"/> Self <input type="checkbox"/> Friends/Relatives <input type="checkbox"/> Web/Internet <input type="checkbox"/> Church/Religious organization <input type="checkbox"/> Other _____ <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	

21. Formerly a ward of child welfare/foster care? (circle one) Yes / No

*22. *RRH & PH Use Only: Permanent Housing Move-in Date:	* RRH & PH Use Only, City Where Housed:	RRH & PH Use Only, Permanent Housing Street Address:
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*23. City where you lost stable housing (does not include shelter, transitional housing, or institutions). For prevention programs, city where you are at-risk of losing your housing?

<input type="checkbox"/> Alamo	<input type="checkbox"/> Byron	<input type="checkbox"/> Danville	<input type="checkbox"/> Kensington	<input type="checkbox"/> Oakley	<input type="checkbox"/> Port Costa
<input type="checkbox"/> Antioch	<input type="checkbox"/> Canyon	<input type="checkbox"/> Discovery Bay	<input type="checkbox"/> Knightsen	<input type="checkbox"/> Orinda	<input type="checkbox"/> Richmond
<input type="checkbox"/> Bay Point	<input type="checkbox"/> Clayton	<input type="checkbox"/> El Cerrito	<input type="checkbox"/> Lafayette	<input type="checkbox"/> Pacheco	<input type="checkbox"/> Rodeo
<input type="checkbox"/> Bethel Island	<input type="checkbox"/> Clyde	<input type="checkbox"/> El Sobrante	<input type="checkbox"/> Martinez	<input type="checkbox"/> Pinole	<input type="checkbox"/> San Pablo
<input type="checkbox"/> Blackhawk	<input type="checkbox"/> Concord	<input type="checkbox"/> Hercules	<input type="checkbox"/> Moraga	<input type="checkbox"/> Pittsburg	<input type="checkbox"/> San Ramon
<input type="checkbox"/> Brentwood	<input type="checkbox"/> Crockett		<input type="checkbox"/> N Richmond	<input type="checkbox"/> Pleasant Hill	<input type="checkbox"/> Walnut Creek

Other Bay Area county:

<input type="checkbox"/> Alameda	<input type="checkbox"/> Marin	<input type="checkbox"/> Monterey	* Zip code of last permanent residence: _____
<input type="checkbox"/> Napa	<input type="checkbox"/> San Francisco	<input type="checkbox"/> San Mateo	
<input type="checkbox"/> Santa Clara	<input type="checkbox"/> Santa Cruz	<input type="checkbox"/> Other county:	
<input type="checkbox"/> Sonoma	<input type="checkbox"/> Solano	<input type="checkbox"/> Client prefers not to answer	

*24. In which city did you sleep last night? (this means: where did you sleep prior to entering this program)

City _____ State _____

*25. If homeless, is this your first time experiencing homelessness (being without housing)? Yes / No

*26. Total length of time client has been homeless (without housing) [short breaks are acceptable]. ____Years ____Months

Health and Disability

*27. Please Circle Yes or No for each of the following disability types:

Physical	Y / N	Long Term and Impairs Independence?	Y / N	Mental health disorder	Y / N	Long Term and Impairs Independence?	Y / N
Developmental	Y / N			Alcohol use disorder	Y / N	Long Term and Impairs Independence?	Y / N
Chronic health condition	Y / N	Long Term and Impairs Independence?	Y / N	Drug use disorder	Y / N	Long Term and Impairs Independence?	Y / N
HIV/AIDS	Y / N			Both Alcohol and Drug disorders	Y / N	Long Term and Impairs Independence?	Y / N

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? (If any of the above conditions are Long Term and Impairs Independence, or if “Y” to Developmental or HIV/AIDS)

Yes No Client doesn't know Client prefers not to answer

* 28. Client's General Health Status [RHY and PSH Programs Only] Poor Fair Good Very Good Excellent

*29. Are you a survivor of domestic violence?

Yes No Client doesn't know Client prefers not to answer

If yes, please indicate when the most recent domestic violence experience occurred:

Within the past 3 months 3-6 months ago 6-12 months ago

One year ago or more Client doesn't know Client prefers not to answer

Are you currently fleeing? Yes No

*30. Are you currently covered by health insurance Yes____ No____ Client doesn't know ____ Client prefers not to answer ____

Please answer Yes or No for each of the following health insurance types:

Health Insurance	Currently covered?	*HOPWA Only: If no, reason?	Health Insurance	Currently covered?	*HOPWA Only: If no, reason?
Medicaid/Medi-Cal	Y / N		Health insurance obtained through COBRA	Y / N	
Medicare	Y / N		Private pay health Insurance	Y / N	
State Children's Health Ins Program (SCHIP)	Y / N		State health insurance for adults	Y / N	
Employer-Provided Health Insurance	Y / N		Indian health services program	Y / N	
Veteran's Health Administration (VHA)	Y / N		Other	Y / N	

*HOPWA only: If not covered, indicate reason: (A= Applied but decision pending, B = Applied but client was ineligible, C = Client did not apply, D = Insurance Type not applicable.)

Income and Employment

***31. Are you employed?** Yes No

If **employed**, type of employment? Full Time Part time Seasonal/Sporadic (or day labor)

Hours Worked Last Week _____ Where? _____

If **unemployed**, why? Looking for work Unable to work Not looking for work

***32. Any income received from any source in the last 30 days?** Yes / No

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):	\$

***33. Any non-cash benefits received in the last 30 days (Y/N)?** _____ (answer yes or no to each of the following):

Source	Received in past 30 days?	Source	Received in past 30 days?
Supplemental nutrition assistance program (SNAP/Food Stamps)	Y / N	TANF Transportation Services	Y / N
Special Supplemental Nutrition Pgm for Women, Infants, & Children (WIC)	Y / N	Other TANF-Funded Services	Y / N
TANF Childcare services	Y / N	Other Non-Cash Benefit	Y / N

Education

34. Last grade completed?

- | | | | |
|--------------------------------------|---|--|---|
| <input type="checkbox"/> < 5th grade | <input type="checkbox"/> 9 th – 11 th Grade | <input type="checkbox"/> School program does not have grade levels | <input type="checkbox"/> Graduate degree |
| <input type="checkbox"/> Grade 5-6 | <input type="checkbox"/> 12 th Grade | <input type="checkbox"/> Some college | <input type="checkbox"/> Vocational certification |
| <input type="checkbox"/> Grade 7-8 | <input type="checkbox"/> GED | <input type="checkbox"/> Associates degree | <input type="checkbox"/> Client doesn't know |
| | | <input type="checkbox"/> Bachelor's degree | <input type="checkbox"/> Client prefers not to answer |

Dependents

***35. Please list information about all dependent children (under 18 years old) in your household who will be participating in this program.**

First and last name	Relationship to HOH	Birth date	SS #	Gender	Race	Program entry date (if different from HoH)	Special needs	Health Insurance	Income

Criminal history

36. Have you ever been convicted of a crime (Y/N)? _____ Explain crime: _____

If yes, were you convicted within the last 6 months (Y/N)? _____

37. Are you currently on probation (Y/N)? _____ Probation office's name and phone no.: _____

Probation end date (mm/dd/yy): ____/____/____

38. Are you currently on parole (Y/N)? _____ Parole office's name and phone no.: _____

Parole end date (mm/dd/yy): ____/____/____

39. Have you ever been incarcerated in State/County/Federal Prison (Y/N)? _____ **If Yes:**

a) Were you released as a result of California Assembly Bill (AB) 109? (circle one) Yes / No

b) Were you released within the last 6 months? (circle one) Yes / No

40. Formerly a ward of juvenile justice system? (circle one) Yes / No

Emergency Contact and Signature

Emergency Contact: _____ **Emergency Contact Phone:** _____

***Signature of the client stating that all information is true and correct:** _____

For PATH Programs Only	For HOPWA Programs Only
<p>1. Date of status determination: ___/___/___</p> <p>2. Client became enrolled in PATH? Yes / No If no, reason not enrolled</p> <p><input type="checkbox"/> Client was found ineligible for PATH</p> <p><input type="checkbox"/> Unable to locate client</p> <p><input type="checkbox"/> Client was not enrolled for other reason(s)</p> <p>3. Connection with SOAR? Yes / No</p>	<p>1. Receiving AIDS Drug Assistance Program (ADAP)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer</p> <p>If no, reason?</p> <p><input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Insurance type N/A for this client</p> <p><input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client doesn't know</p> <p><input type="checkbox"/> Client did not apply <input type="checkbox"/> Client prefers not to answer</p> <p>2. Receiving Ryan White-funded Medical or Dental Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer</p> <p>If no, reason?</p> <p><input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Insurance type N/A for this client</p> <p><input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client doesn't know</p> <p><input type="checkbox"/> Client did not apply <input type="checkbox"/> Client prefers not to answer</p> <p>3. T-cell (CD4) count available? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer</p> <p>If yes, T-Cell counts? (0-1500): _____</p> <p>How was the data obtained?</p> <p><input type="checkbox"/> Medical Report</p> <p><input type="checkbox"/> Client Report</p> <p><input type="checkbox"/> Other</p> <p>4. Viral load available? <input type="checkbox"/> Available <input type="checkbox"/> Not Available <input type="checkbox"/> Undetectable <input type="checkbox"/> Client prefers not to answer</p> <p>If available, viral load? (0-99999) _____</p> <p>How was the data obtained?</p> <p><input type="checkbox"/> Medical Report</p> <p><input type="checkbox"/> Client Report</p> <p><input type="checkbox"/> Other</p> <p>5. Prescribed Anti-Retroviral? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer</p>
For VASH Programs Only	
<p>1. VAMC station number: _____</p>	
For SSVF Programs Only	
<p>1. Percentage of Area Median Income (AMI) <i>[HUD sets new AMI income limits each year. Please refer to huduser.org for the current AMI limits.]</i></p> <p><input type="checkbox"/> 30% or less</p> <p><input type="checkbox"/> 31% to 50%</p> <p><input type="checkbox"/> 51% to 80%</p> <p><input type="checkbox"/> 81% or greater</p> <p>2. VAMC station number: _____(Required)</p> <p>2. Connection with SOAR? Yes / No</p>	

For SSVF Prevention Programs

Is Homelessness Prevention Targeting Screener required? Yes / No

If yes, please answer all questions below.

	Points		Points
<p>Current housing loss expected within... (select only one)</p> <p><input type="checkbox"/> 1-6 days</p> <p><input type="checkbox"/> 7-13 days</p> <p><input type="checkbox"/> 14-21 days</p> <p><input type="checkbox"/> More than 21 days (0 points)</p>		<p>Current household income is</p> <p><input type="checkbox"/> \$0 (i.e., not employed, not receiving cash benefits, no other <u>current</u> income)</p> <p><input type="checkbox"/> 1-14% of Area Median Income (AMI) for household size</p> <p><input type="checkbox"/> 15-30% of AMI for household size</p> <p><input type="checkbox"/> More than 30% of AMI for household size</p>	
<p>Past experience of homelessness (street / shelter / transitional housing) (any adult)</p> <p><input type="checkbox"/> Most recent episode occurred within the last year</p> <p><input type="checkbox"/> Most recent episode occurred more than one year ago</p> <p><input type="checkbox"/> None (0 points)</p>		<p>Head of Household is not a current leaseholder/renter of unit</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	
<p>Head of Household (HOH) never been a leaseholder/renter of unit</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>		<p>Currently at risk of losing a tenant-based housing subsidy or housing in a subsidized building or unit?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	
<p>Rental evictions within the past 7 years (any adult)</p> <p><input type="checkbox"/> no prior rental evictions</p> <p><input type="checkbox"/> 1 prior rental eviction</p> <p><input type="checkbox"/> 2 or more prior rental evictions</p>		<p>Criminal record for arson, drug dealing or manufacture, or felony offense against persons or property? (any adult)</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	

Incarcerated as adult (any adult in household) <input type="checkbox"/> Not incarcerated <input type="checkbox"/> Incarcerated once <input type="checkbox"/> Incarcerated two or more times		Discharged from jail or prison within last six months after incarceration of 90 days or more (adults) <input type="checkbox"/> No <input type="checkbox"/> Yes	
Registered sex offender? <input type="checkbox"/> No <input type="checkbox"/> Yes		Head of household with disabling condition (physical health, mental health, substance use) that directly affects ability to secure/maintain housing? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Currently pregnant (any household member) <input type="checkbox"/> No <input type="checkbox"/> Yes		Single parent/guardian household with minor child(ren)? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Household includes one or more young children (age 6 or under), or a child who requires significant care <input type="checkbox"/> No <input type="checkbox"/> Youngest child is under 1 year old <input type="checkbox"/> Youngest child is 1 to 6 years old and/or one or more children (any age) require sig		Household size of 5 or more requiring at least 3 bedrooms (due to age/gender mix)? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Household includes one or more members of an overrepresented population in the homelessness system when compared to the general population <input type="checkbox"/> No <input type="checkbox"/> Yes			
		HP Applicant Total Points	Grantee Targeting Threshold Score