

*Team Name: _____

Complete one intake for each family member and child. Complete only * items for each child.



*Intake Date: ____/____/____

Outreach HMIS Intake Form

| | | | | |
|---|--------------------|-------------------|---|----------------|
| *First Name | Middle | *Last Name | Jr/Sr | Nickname/Alias |
| Self / Child / Spouse or Partner / Other Non-Relative | | | | |
| *Social Security Number | *Birth Date | Age | *Relationship to Head of Household | |

Background Information

Best Phone No.: _____ Email Address: _____

***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 | | | |

***Sexual orientation:** Straight Gay Lesbian Bisexual Questioning/Unsure Other: _____ Client prefers not to answer

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

| | | |
|--|--|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Native Hawaiian or Pacific Islander | <input type="checkbox"/> Client Doesn't Know |
| <input type="checkbox"/> Asian or Asian American | <input type="checkbox"/> Middle Eastern or North African | <input type="checkbox"/> Client prefers not to answer |
| <input type="checkbox"/> Black, African-American, or African | <input type="checkbox"/> Hispanic/Latina/e/o | <input type="checkbox"/> Additional Race and Ethnicity Detail: _____ |
| <input type="checkbox"/> American Indian/Alaskan Native/Indigenous | | |

***Do you need translation assistance:** Yes / No If yes, preferred language(s)? _____

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

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

Army Navy Airforce Marines Coast Guard Space Force

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

Era (check all that apply):

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

Discharge Status:

Honorable Bad Conduct Client prefers not to answer
 General under honorable conditions Dishonorable Uncharacterized/Other
 Other than honorable (OTH) Client doesn't know

*Present Living Situation (circle one):

Emergency shelter, including hotel or motel paid for with emergency shelter voucher Place not meant for habitation including non-housing service site Other: _____

If place not meant for habitation, specify below:

Street/sidewalk Park
 Car Abandoned building
 RV / Camper Bus/train station
 Does the car or RV work? Under a bridge /overpass
 Y or N Outdoor encampment/ woods

*Length of present living situation (circle one):

One night or less One month or more, but less than 90 days Client doesn't Know
 Two nights to six nights 90 Days or more, but less than one year Client prefers not to answer
 One week or more, but less than one month One year or longer

***If less than 30 days, where were you living before?** (See choices under Present Living Situation) _____

***Approximate date CURRENT episode of homelessness started (breaks of less than 7 days are acceptable)** ____/____/____

***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 lost stable housing** _____ ***Zip code where you lost 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

Housing Status at Program Entry

Category 1 – Homeless (i.e. streets, shelter, transitional housing) Category 3 – Homeless only under other federal statutes At risk of homelessness
 Category 2 – At imminent risk of losing housing (within 14 days) Category 4 – Fleeing domestic violence Stably Housed

Cause of homelessness? (check all that apply)

| | | |
|---|--|--|
| <input type="checkbox"/> Divorce/Separation | <input type="checkbox"/> Domestic violence | <input type="checkbox"/> Eviction |
| <input type="checkbox"/> Loss of job | <input type="checkbox"/> Low income /Underemployment | <input type="checkbox"/> Mental health |
| <input type="checkbox"/> Parole | <input type="checkbox"/> Ran away | <input type="checkbox"/> Rent increase |
| <input type="checkbox"/> Substance abuse | <input type="checkbox"/> Thrown out | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Physical health | | |

How did you hear about CORE Outreach? _____

What brought you to this city? (check one)

- I grew up here
- Family/friends live here
- This city is all I know
- Just passing through
- My services are here (i.e., doctor, MH, PO Box, Foodbank, church)
- Just released from local detention facility
- Public transport is where I sleep
- Just released from local hospital ER
- Just released from Psych Emergency
- Other: _____

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

PES Referral? Yes / No Jail Referral? Yes / No CoCo LEAD+ Referral? 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

Have you ever willingly performed or been threatened, coerced, or manipulated to perform a sexual act in exchange for money/goods? Yes / No

Have you ever been threatened, coerced, or manipulated to work without pay? Yes / No

Former Foster Youth? Yes / No

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

Health Insurance

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

- Medicaid
- Medicare
- State Children's Health Insurance Program
- Veteran's Health Administration (VHA)
- Employer-Provided Health Insurance
- COBRA
- Private Pay Health Insurance
- State Health Insurance for Adults
- Indian Health Services Program
- Other Health Insurance
- Specify Other: _____

*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 |

*Do you have a Disabling Condition? This means: Do you have a condition of expected long duration that substantially limits your ability to live on your own

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

Contact

Services Provided (Referral/Placement/Coordination)

| | |
|---|--|
| <p>Time of Contact: _____</p> <p>City of Contact: _____</p> <p>* Current Living Situation: _____</p> <p>City Living In: _____</p> <p>If above is not streets/shelter, is client going to have to leave their living situation within 14 days? Yes / No, If Yes:</p> <div style="border: 1px solid black; padding: 5px;"> <p>Has a subsequent residence been identified? Yes / No</p> <p>Does client have resources/support networks to obtain other permanent housing? Yes / No</p> <p>Had their own housing unit in last 60 days? Yes / No</p> <p>Moved 2 or more times in last 60 days? Yes / No</p> </div> | <p>Indicate which shelter, facility, center</p> <ul style="list-style-type: none"> <input type="checkbox"/> Shelter: _____ R / P <input type="checkbox"/> AOD Treatment : _____ R / P <input type="checkbox"/> Hospital: _____ R / C <input type="checkbox"/> Outpatient Medical : _____ R / C <input type="checkbox"/> MH Clinic: _____ R / C <input type="checkbox"/> Linkage to HMIOT: _____ <input type="checkbox"/> CARE Center : _____ R / C <input type="checkbox"/> Benefits worker – Specify benefits _____ R / C <input type="checkbox"/> HCH Mobile Clinic: _____ R / C <input type="checkbox"/> Warming Center: _____ R / P <ul style="list-style-type: none"> <input type="checkbox"/> Warming Center (East) <input type="checkbox"/> Warming Center (West) <input type="checkbox"/> Sobering Center <input type="checkbox"/> DMV <input type="checkbox"/> Medication Pick-Up <input type="checkbox"/> VASH/SSVF/VA Benefit Referral <input type="checkbox"/> Bus/BART Ticket(#): _____ <input type="checkbox"/> Animal Services <input type="checkbox"/> Emergency Supplies |
|---|--|

*Living Situation Options: • Hospital • Hotel/Motel • Friend's room/apt • Family members room/apt • Jail/Prison/Juvi • Psych facility • Substance abuse/detox • Nursing home or Board & Care • Rental w/out ongoing subsidy Rental w/ongoing subsidy Rental w/GDP TIP Rental w/ VASH • Rental w/ RRH subsidy • Rental w/HCV • Rental w/Other Subsidy • Housing Stability Voucher • Family Unification Program Voucher • Perm. Supportive Housing • Own home no subsidy • Own home w/ subsidy

Emergency Contact Person _____ Phone No. _____