*Team Name: ____________

*Intake Date: ____/____/____

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

# Outreach HMIS Youth Intake Form

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

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

## Release of Information

I give authorization for my basic and personal information (including, but not limited to, name, gender, birth date, ethnicity, household configuration, military status, and non-confidential services requested and received) to be shared with the organizations under which the CORE Outreach team operates and authorized staff of partner agencies in order to assist me in gaining access to services that I may need including housing, employment, financial assistance, vocational services, counseling and medical/mental health treatment. I understand that as I receive services, information will be collected and entered into the Homeless Management Information System (HMIS).

I understand that authorizing my information to be entered into the HMIS is voluntary. Refusing to do so will not limit my access to shelter or services. I understand that I have the right to receive a copy of my HMIS information upon written request. I understand that I may cancel this authorization at any time by written request to the County Homeless Program at 2400 Bisso Lane, Ste D2, CA 94520, but that the cancellation will not be retroactive.

________________________________________ ____________________

Signature of Client Date

## Background Information

**Best Phone No.:** ______________________ **Email Address:** ______________________

***Gender:**
- ❑ Man (Boy if child)
- ❑ Woman (Girl if child)
- ❑ Transgender
- ❑ Questioning
- ❑ Non-Binary
- ❑ Culturally Specific Identity (e.g., Two-Spirit)
- ❑ Different Identity: ____________________
- ❑ Client doesn't know
- ❑ Client prefers not to answer

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

***What Race BEST describes you? (circle all that apply)**
- ❑ White
- ❑ Asian or Asian American
- ❑ Black, African-American, or African
- ❑ American Indian/Alaskan Native/Indigenous
- ❑ Native Hawaiian or Pacific Islander
- ❑ Middle Eastern or North African
- ❑ Hispanic/Latina/e/o
- ❑ Client Doesn't Know
- ❑ Client prefers not to answer
- ❑ Additional Race and Ethnicity Detail: ____________________

***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
- ❑ 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 prefers nc

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

***Length of present living situation (circle one):**
- ❑ 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 prefers not to answer

***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** ________________ ***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 2 – At imminent risk of losing housing (within 14 days)
- ❑ Category 3 – Homeless only under other federal statutes
- ❑ Category 4 – Fleeing domestic violence
- ❑ At risk of homelessness
- ❑ Stably Housed



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**Cause of homelessness? (check all that apply)**

- ❑ Divorce/Separation
- ❑ Loss of job
- ❑ Parole
- ❑ Substance abuse
- ❑ Physical health
- ❑ Domestic violence
- ❑ Low income /Underemployment
- ❑ Ran away
- ❑ Thrown out
- ❑ Eviction
- ❑ Mental health
- ❑ Rent increase
- ❑ Other:______________________

**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

**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

**Foster Youth or Ward of the Court?** Yes/ No / don't know / Refused

**Have you ever been involved with juvenile justice system?** Yes/ No / don't know / Refused

**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)
- ☐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 |

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

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

## Contact

**Time of Contact:** ___:_______

***Location of Contact:**

- ❑ Not staying on streets,ES,EH
- ❑ Staying on the streets ,ES,EH
- ❑ Worker unable to determine

***City of Contact:** _______________

**Dispatch Ticket #:** _______________

**Encampment/Location:**

______________________________

## Services Provided (Referral/Placement/Coordination)

**Indicate which shelter, facility, center**

- ❑ **Shelter:** ______________________________ R / P
- ❑ **AOD Treatment :** ______________________________ R / P
- ❑ **Hospital:** ______________________________ R / C
- ❑ **Outpatient Medical :** ______________________________ R / C
- ❑ **MH Clinic:** ______________________________ R / C
- ❑ **CARE Center :** ______________________________ R / C
- ❑ **Benefits worker – Specify benefits** _______________ R / C
- ❑ **HCH Mobile Clinic:** ______________________________ R / C
- ❑ **Warming Center**: ______________________________ R / P

- ❑ Warming Center (East)
- ❑ Warming Center (West)
- ❑ Sobering Center
- ❑ DMV
- ❑ Medication Pick-Up
- ❑ VASH/SSVF/VA Benefit Referral
- ❑ Bus/BART Ticket(#):_____
- ❑ Animal Services
- ❑ Emergency Supplies

**Emergency Contact Person** ______________________________**Phone No.** ______________________________



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