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HMIS #:  
CM Name:  
Project Entry Date:

**Santa Barbara County HMIS  
Standardized Intake: Adult Exit**

This form is designed to be completed by a service provider while interviewing a client.

A separate Standardized Intake form should be completed for each member of the household.

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| **Household Information**  Is client:  Single Adult  Adult in Household | | | |
| **If check Single Adult** | Go to Client Profile | | |
| **If checked Adult in Household** | Are you the Head of Household (HoH)? Yes No | | |
|  | If no, name of HoH: | | |
|  | How many adults in household?: | | |
|  | How many children in household?: | | |
| **If checked Child** | Name of HoH: | | |
| **If you are in a household, what is your relationship to the HoH?** | Self ( head of household)  Head of household’s child   Head of household’s spouse or partner   Other relation to head of household)   Other: non-relation member | | |
| **Client Profile** | | | |
| **First Name** | |  | **Middle** |
| **Last Name** | |  | |
| **Social Security Number** | |  | |
| **U.S. Military Veteran** | |  Yes   No |  Client Doesn’t Know   Client Refused |

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| **Reason for Leaving & Destination** | | |
| **Reason for Leaving** |  Completed Program   Criminal Activity/Violence   Death   Disagreement with rules/persons   Left for housing opportunity   Needs could not be met |  Non-compliance   Non-payment of rent   Reach max time allowed   Other   Client Doesn’t Know   Client Refused   Unknown/Disappeared |
| **If Other, Specify:** |  | |
| **Destination** |  Deceased   Emergency shelter, including hotel or motel paid for with emergency shelter voucher   Foster care or foster care group home   Hospital or other non-psychiatric medical facility   Hotel or motel paid for w/o emergency shelter voucher   Jail, prison or juvenile detention facility   Long-term care facility or nursing home   Moved from one HOPWA funded project to HOPWA PH   Moved from one HOPWA funded project to HOPWA TH   Owned by client, no ongoing housing subsidy   Owned by client, with ongoing subsidy   Permanent housing (other than RRH) for formerly homeless persons   Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)   Psychiatric hospital or other psychiatric facility   Rental by client, no ongoing housing subsidy   Rental by client, with RRH or equivalent subsidy   Rental by client, with VASH subsidy   Rental by client, with GDP TIP subsidy   Rental by client, with other ongoing subsidy   Residential project or halfway house with no homeless criteria   Safe Haven   Staying or living with family, permanent tenure   Staying or living with family, temporary tenure (e.g. room apartment or house)   Staying or living with friend, permanent tenure   Staying or living with friends, temporary tenure (e.g. room apartment or house)   Substance abuse treatment facility or detox center   Transitional housing for homeless persons (including homeless youth)   Other   No exit interview completed   Client doesn’t know   Client refused   Data not collected | |
| **If Other, Specify:** |  | |

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| Housing Move-in Date |  |

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| **Monthly Income – Cash Benefits** | |
| **Income from any source?** | Yes No Client doesn’t know Client refused |
| **Total monthly income:** | $ |
|  Alimony or Other Spousal Income $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   Child Support $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   Earned Income $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   General Assistance $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   Other $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  If Other specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Pension or retirement from another job $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   Private disability insurance $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  Retirement income from Social Security $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   SSDI $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   SSI $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   TANF $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   Unemployment Insurance $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   VA Non-service connect disability pension $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   VA Service connected disability compensation $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   Worker’s compensation $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **Non-Cash Benefits** | |
| **Income from any source?** | Yes No Client doesn’t know Client refused |
|  Special supplement nutrition program for WIC  $   Supplemental nutrition assistance program  (Food Stamps) $   TANF-Child care services $ |  TANF Transportation services$   Other TANF funded services $   Other Source  If Other, specify: |

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| **Health Insurance** | |
| **Covered by health insurance?** | Yes No Client doesn’t know Client refused |
|  Medicaid   Medicare   State children’s health insurance program   VA Medical Services   Employer provided |  Private pay health plan   State health insurance for adults   Indian health services program   Other Source  If Other, specify: |

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| **Disability** | | | | | | | | |
| **Does the client have a disabling condition?** | | | |  Yes   No | |  Client Doesn’t Know   Client Refused | | |
| **If Yes, please complete the following for each disability type** | | | | | | | | |
| **Alcohol Abuse** | |  Yes  No  Client Doesn’t Know   Client Refused | | Condition Long term? | | |  Yes  No  Client Doesn’t Know  Client Refused | |
| **Disability State Date** | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? | | |  Yes  No  Client Doesn’t Know  Client Refused | |
| **Both Alcohol & Drug Abuse**  **Disability Start Date** | |  Yes  No  Client Doesn’t Know   Client Refused  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Condition Long term? | | |  Yes  No  Client Doesn’t Know  Client Refused | |
| If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? | | |  Yes  No  Client Doesn’t Know  Client Refused | |
| **Chronic Health Condition**  **Disability Start Date** | |  Yes  No  Client Doesn’t Know   Client Refused  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Condition Long term? | | |  Yes  No  Client Doesn’t Know  Client Refused | |
| If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? | | |  Yes  No  Client Doesn’t Know  Client Refused | |
| **Developmental** | |  Yes  No  Client Doesn’t Know   Client Refused | | Condition Long term? | | |  Yes  No  Client Doesn’t Know  Client Refused | |
| **Disability State Date** | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? | | |  Yes  No  Client Doesn’t Know  Client Refused | |
| **Drug Abuse**  **Disability Start Date** | |  Yes  No  Client Doesn’t Know   Client Refused  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Condition Long term? | | |  Yes  No  Client Doesn’t Know  Client Refused | |
| If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? | | |  Yes  No  Client Doesn’t Know  Client Refused | |

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| **Disability** | | | |
| |  |  |  |  | | --- | --- | --- | --- | | **HIV/AIDS** |  Yes  No  Client Doesn’t Know   Client Refused | Condition Long term? |  Yes  No  Client Doesn’t Know  Client Refused | | **Disability State Date** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? |  Yes  No  Client Doesn’t Know  Client Refused | | | | |
| **Mental Health Problem** |  Yes  No  Client Doesn’t Know   Client Refused | Condition Long term? |  Yes  No  Client Doesn’t Know  Client Refused |
| **Disability State Date** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? |  Yes  No  Client Doesn’t Know  Client Refused |
| **Physical** |  Yes  No  Client Doesn’t Know   Client Refused | Condition Long term? |  Yes  No  Client Doesn’t Know  Client Refused |
| **Disability State Date** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? |  Yes  No  Client Doesn’t Know  Client Refused |

*I (Adult client or Head of Household) certify that the information I have provided here is true/correct to the best of my knowledge.*

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| Print Name of Client | Signature of Client | Date |
| Print Name of Intake Worker | Signature of Intake Worker | Date |