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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 SourceIf 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 SourceIf 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** |
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| **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 |

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| **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 |