

HMIS #  
CM Name   
Project Start Date / /

**Santa Cruz County FEMA COVID-19 Intake**

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

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

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| **Household Information**  Is client:  Single Adult  Adult in Household | | | | | |
| **If checked Single Adult** | Go to Client Profile | | | | |
| **If checked Adult in Household** | Are you the Head of Household (HoH)? Yes No | | | | |
| **If you are in a household, what is your relationship to the HoH?** | Husband  Wife Daughter Son  Father  Mother | Sister  Brother  Roommate  Grandchild | Aunt  Uncle  Niece  Nephew  Grandparent | Significant Other  Domestic Partner  Other Stepdaughter  Stepson | |
| **Client Profile** | | | | |
| **Social Security Number** |  | |  | |
| **Quality of SSN** |  Full SSN Reported Approximate or partial SSN reported | |  Client Doesn’t Know  Client Refused | |
| **First Name** |  | | **Middle** | |
| **Last Name** |  | |  | |
| **Quality of Name** |  Full Name Reported  Partial, Street Name, or Code Name | |  Client Doesn’t Know  Client Refused | |
| **Date of Birth** | \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_  (mm/dd/yyyy) | | | |
| **Quality of DOB** |  Full DOB Reported Approximate or partial DOB | |  Client Doesn’t Know  Client Refused | | |
| **Gender** |  Female   Male   Trans Female (MTF or Male to Female)  Trans Male (FTM or Female to Male) | | Gender Non-Conforming (i.e. not exclusively male or female)  Client Doesn’t Know   Client Refused | | |
| **Ethnicity**   Non-Hispanic/Non-Latino   Hispanic/Latino   Client Doesn’t Know   Client Refused | **Race**  White  Black or African American Asian  American Indian or Alaska Native | |  Native Hawaiian or  Other Pacific Islander  Client Doesn’t Know   Client Refused | | |

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| **3. 917A Prior Living Situation** | | |
| **Type of Residence** | Homeless Situation  Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport/or anywhere outside)  Emergency Shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter  Safe Haven  Institutional Situations  Foster care home or foster care group home  Hospital or other residential non—psychiatric medical facility  Jail, prison or juvenile detention facility  Long-term care facility or nursing home  Psychiatric hospital or other psychiatric facility  Substance abuse treatment facility or detox center  Transitional & Permanent Housing Situatio**n**   Residential project or halfway house with no homeless criteria  Hotel or motel Paid for without emergency shelter voucher  Transitional housing for homeless persons (including homeless youth)  Host Home (non-crisis)   Staying or living in a friend’s room, apartment or house  Staying or living in a family member’s room, apartment or house  Rental by client with GPD TIP housing subsidy  Rental by client, with VASH housing subsidy  Permanent housing (other than RRH) for formerly homeless persons  Rental by client, with RRH or equivalent subsidy  Rental by client, with HCV voucher (tenant or project based)  Rental by client in a public housing unit  Rental by client, no ongoing housing subsidy  Rental by client, with other ongoing housing subsidy  Owned by client, with ongoing housing subsidy  Owned by client, no ongoing housing subsidy  Other  Client doesn’t know Client refused | |
| **Length of stay in previous place** |  One night or less  Two 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 refused |
| **Approximate date homelessness started:** | \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ | |
| **Regardless of where they stayed last night: Number of times the client has been on the streets, in ES, or SH in the past three years including today** | One Time  Two Times  Three Times | Four or more times  Client doesn’t know  Client refused |
| **Total number of months homeless on the street, in ES, or SH in the past three years** |  One month (this time is the first month)  2 3  4 5 6 7 | 8 9 10 11  12 More than 12 months  Client doesn’t know Client refused |

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| **Last or Current Permanent Address** | | | |
| **Address** |  | | |
| **City** |  | | **County** |
| **State** |  |  | **Zip Code** |
| **Address Data Quality** | Full Address Reported Incomplete or Estimated Address Reported | |  Client Doesn’t Know  Client Refused |

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| **Additional FEMA Questions** | | | | |
| **Cell Phone** |  | | |  Client Doesn’t Know   Client Refused |
| **Email Address** |  | | |  Client Doesn’t Know   Client Refused |
| **Pets in Household** |  Yes  No | |  Client Doesn’t Know   Client Refused | |
| **Service Animal in Household** |  Yes  No |  |  Client Doesn’t Know   Client Refused | |
| **Access/Functional Needs Identified** |  Yes  No |  |  Client Doesn’t Know   Client Refused | |

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| **Disabling Condition** | | |
| **Does the client have a disabling condition?** |  Yes  No |  Client Doesn’t Know   Client Refused |

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| **FEMA Data Collection** | | | |
| **COVID-19 Screening Results for Qualifying Household Members** |  Asymptomatic Low Risk  Asymptomatic High Risk | |  COVID-19 Exposed  COVID-19 Positive |
| **Unit Name** |  | | |
| **Unit Type** |  Hotel/Motel  Shelter  Apartment |  |  Trailer  Other |
| **Address** |  |  |  |
| **City** |  |  | **County** |
| **State** |  |  | **Zip Code** |