

Agency: _____ Project Entry Date: _____

Project: _____ Case Worker: _____

Hawaii HMIS Add New Client: Identifying

Name Quality*: ☐ Full name ☐ Partial, street/code name ☐ Client doesn't know ☐ Client prefers not to answer
☐ Data not collected

First Name*: _____ Last Name*: _____

Middle Name: _____ Suffix: _____

Birth Date*: _____ ☐ Full DOB ☐ Partial (DD/YY) ☐ Client prefers not to answer
☐ Partial (MM/YY) ☐ Client doesn't know ☐ Data not collected Age: _____

Social Security#: _____ ☐ Full ☐ Partial ☐ Client prefers not to answer
☐ Client doesn't know ☐ Data not collected

Gender* ☐ Man (Boy, if child) ☐ Culturally specific identity (e.g. Two-spirit) ☐ Client doesn't know
☐ Woman (Girl, if child) ☐ Non-Binary ☐ Client prefers not to answer
☐ Transgender ☐ Different identity * _____ ☐ Data not collected
☐ Questioning

Primary Language* ☐ Chinese ☐ Korean
☐ Chuukese ☐ Marshallese
☐ English ☐ Spanish
☐ Ilocano ☐ Tagalog
☐ Japanese ☐ Vietnamese

Other: _____

If Non-US Citizen COFA* ☐ Pohnpei-Micronesia
☐ Chuuk-Micronesia ☐ Yap-Micronesia
☐ Kosrae-Micronesia ☐ Client Doesn't know
☐ Marshall Islands ☐ Client prefers not to answer
☐ Palau ☐ Data Not collected

Relationship to Head of Household* ☐ Self (H of H) ☐ Guardian ☐ Veteran Status* ☐ Client doesn't know
☐ Spouse ☐ Grandchild ☐ No ☐ Client prefers not to answer
☐ Child ☐ Other Relative ☐ Yes ☐ Data not collected
☐ Step Child ☐ Other Non-Relative
☐ Foster Child ☐ Unknown
☐ Grandparent

Race* (Select all that apply)
☐ American Indian, Alaskan Native or Indigenous ☐ Native Hawaiian or Pacific Islander*
☐ Asian or Asian American* ☐ White
☐ Black, African American, African ☐ Client doesn't know
☐ Hispanic/Latina/e/o ☐ Client prefers not to answer
☐ Middle Eastern/North African ☐ Data not collected

Additional Race and Ethnicity detail: _____

If Asian Chosen Above* ☐ Filipino ☐ Vietnamese
☐ Asian Indian ☐ Japanese ☐ Other Asian
☐ Chinese/Taiwanese ☐ Korean

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HUD Universal Data

Client location*(provider) MATCH PROGRAM NAME Continuum of Care Code: (Self Populates in HMIS)**Disabling Condition*** ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected**LIVING SITUATION – Type of Residence Prior to Project Entry (Select only one answer)**

A. HOMELESS SITUATION

- ☐ Emergency shelter, including hotel or motel paid with emergency shelter voucher, Host Home Shelter
- ☐ Safe Haven

- ☐ Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)

B. INSTITUTIONAL SITUATION

- ☐ 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

C. TEMPORARY HOUSING SITUATION

- ☐ Hotel or motel paid for without emergency shelter voucher
- ☐ Host home (non-crisis)

- ☐ Staying or living in a friend's room, apartment, or house
- ☐ Transitional housing for homeless persons (including homeless youth)

- ☐ Staying or living in a family member's room, apartment, or house

- ☐ Residential project or halfway house with no homeless criteria

D. PERMANENT HOUSING SITUATION

- ☐ Rental by client, no ongoing housing subsidy
- ☐ Rental by client, with ongoing housing subsidy* (select below):

- ☐ Owned by client, with ongoing housing subsidy
- ☐ Owned by client, no ongoing housing subsidy

- * Subsidy type ☐ Housing stability voucher
- ☐ Family Unification Program voucher (FUP)
- ☐ Foster Youth to Independence Initiative (FYI)
- ☐ HCV voucher (tenant or project based)
- ☐ GIP TPD housing subsidy
- ☐ Other permanent housing dedicated for formerly homeless persons

- ☐ Permanent supportive housing
- ☐ Public housing unit
- ☐ Rental by client, with other ongoing housing subsidy
- ☐ RRH or equivalent
- ☐ VASH housing subsidy

E. OTHER

- ☐ Client doesn't know
- ☐ Client prefers not to answer

- ☐ Data not collected

Length of Stay in the Prior Living Situation:

Approximate date this episode of homelessness started: _____

- ☐ 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 prefers not to answer
- ☐ Data not collected

(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 ☐ Four or more times
- ☐ Two times ☐ Client doesn't know
- ☐ Three times ☐ Client prefers not to answer
- ☐ Data not collected

Total number of months homeless on the streets, in ES, or SH in the past three years:

- ☐ One month (this time is the 1st month)
- ☐ 2 ☐ 6 ☐ 10 ☐ More than 12 months
- ☐ 3 ☐ 7 ☐ 11 ☐ Client doesn't know
- ☐ 4 ☐ 8 ☐ 12 ☐ Client prefers not to answer
- ☐ 5 ☐ 9 ☐ Data not collected

HUD Program Data**Domestic violence – Survivor of Domestic Violence***

☐ No ☐ Yes* ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

If yes, when experience occurred*

☐ Within the past three months ☐ Client doesn't know
☐ Three to six months (excluding six months exactly) ☐ Client prefers not to answer
☐ From six months to one year (excluding one year exactly) ☐ Data not collected
☐ One year ago or more

Are you currently fleeing?*

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

Non-Cash Benefits from Any Sources* (Received non-cash benefits in the past 30 days; expect to receive them again next month?)

☐ No ☐ Yes* ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

If yes, please mark all that are applicable:

☐ SNAP (Food Stamps) ☐ TANF Transportation Services
☐ WIC-Nutrition for Women, Infants, Children ☐ Other TANF-Funded Services
☐ TANF Child Care Services ☐ Other source: _____

Health Insurance* Are you covered by health insurance?

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

Disabling Condition***Substance Use Disorder*** (If "NO" selected, skip to Mental Health)

☐ No ☐ Drug Use Disorder ☐ Both Alcohol and Drug Use Disorder
☐ Alcohol Use Disorder ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

a) Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

Mental Health Disorder* (If "NO" selected, skip to Developmental Disability)

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

a) Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

Developmental Disability* (If "NO" selected, skip to Chronic Health Condition)

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

Chronic Health Condition* (If "NO" selected, skip to HIV / AIDS)

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

a) Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

HIV / AIDS* (If "NO" selected, skip to Physical Disability) (as applicable)

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

Physical Disability* (If "NO" selected, skip to Health Insurance Assessment)

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

a) Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

HUD Program Data (continued)**Translation Assistance: Translation Assistance Needed***

- ☐ No ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
☐ Yes* **If "Yes", Preferred language:**
☐ Cantonese ☐ Korean ☐ Russian ☐ Vietnamese
☐ Chamorro ☐ Laotian ☐ Samoan ☐ Visayan
☐ Chuukese ☐ Mandarin ☐ Spanish ☐ Client doesn't know
☐ Hawaiian ☐ Marshallese ☐ Tagalog ☐ Client prefers not to answer
☐ Ilokano ☐ Pohnpeian ☐ Thai ☐ Data not collected
☐ Japanese ☐ Portuguese ☐ Tongan ☐ Other _____

Health Insurance Assessment (if yes to health insurance)

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

HUD Financial Assessment

Area Median Income* ☐ Big Island ☐ Kauai ☐ Maui

Income from Any Source* ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

Please check all resources and enter the amount per MONTH*

<u>Income Type</u>	<u>Amount</u>	<u>Income Type</u>	<u>Amount</u>
<input type="checkbox"/> Unemployment	\$ _____	<input type="checkbox"/> Retirement from Social Security:	\$ _____
<input type="checkbox"/> Earned Income (employment):	\$ _____	<input type="checkbox"/> VA Non-Service Disability Pension	\$ _____
<input type="checkbox"/> SSI:	\$ _____	<input type="checkbox"/> Pension or Retirement Income (job):	\$ _____
<input type="checkbox"/> SSDI:	\$ _____	<input type="checkbox"/> Child Support:	\$ _____
<input type="checkbox"/> VA Service Disability Compensation:	\$ _____	<input type="checkbox"/> Alimony or Other Spousal Support:	\$ _____
<input type="checkbox"/> Private Disability Insurance:	\$ _____	<input type="checkbox"/> Worker's Compensation:	\$ _____
<input type="checkbox"/> TANF	\$ _____	<input type="checkbox"/> Other:	\$ _____
<input type="checkbox"/> General Assistance:	\$ _____	TOTAL INCOME:	\$ _____

Hawaii Specific Assessment**Hawaii Residence Information**

Did you arrive in Hawaii during the past 12 months?*

- ☐ No ☐ Yes ☐ Client doesn't know ☐ Client Prefers not to answer

If yes, how long have you been in Hawaii? # of months: _____ **If in Hawaii less than one month, # of days:** _____

How long have you lived in Hawaii over your lifetime?* # of years: _____

Before your 18th birthday, were you placed in an out of home placement and/or experience homelessness?

Check all that apply.

- ☐ Foster Care ☐ Juvenile Home ☐ No ☐ Client doesn't know
☐ Group Home ☐ Homeless ☐ Client prefers not to answer

Hawaii Specific Assessment (continued)**Personal Information****Marital Status*:**

- | | | | |
|---|---|--------------------------------------|---|
| <input type="checkbox"/> Single/never married | <input type="checkbox"/> Married | <input type="checkbox"/> Widowed | <input type="checkbox"/> Client prefers not to answer |
| <input type="checkbox"/> Living with partner | <input type="checkbox"/> Separated/divorced | <input type="checkbox"/> Other _____ | |

What is your current criminal justice status*

- | | | |
|---|--|---|
| <input type="checkbox"/> Parole | <input type="checkbox"/> Formerly in system & completed requirements | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Probation | <input type="checkbox"/> Drug court | <input type="checkbox"/> Client prefers not to answer |
| <input type="checkbox"/> Supervised release | <input type="checkbox"/> None | <input type="checkbox"/> Data not collected |
| | <input type="checkbox"/> Other _____ | |

If the client's residence just prior to project entry was an ES, TH, or PSH project, please specify which one?

Zip code of last permanent address* _____

Zip Code Data Quality*: ☐ Full or Partial

☐ Client doesn't know ☐ Client prefers not to answer

If currently working, # hours worked in past week? _____

Referral Information* (How were you referred to this agency?)

- | | | | |
|---|---|-------------------------------|--|
| <input type="checkbox"/> Aloha United Way | <input type="checkbox"/> Homeless services agency | <input type="checkbox"/> Self | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Criminal justice | <input type="checkbox"/> Hospital | <input type="checkbox"/> VA | <input type="checkbox"/> Other _____ |

If homeless service agency, which one?* _____

Medical Information

Name of Medical Insurer: _____

Emergency Services

How many times in the past 12 months have you used the following emergency or medical services?

Hospital emergency room services..... # of times used: _____

Other hospital services (medical or psychiatric) # of times used: _____

911/ambulance emergency services..... # of times used: _____

Access (Crisis) hotline..... # of times used: _____

Other emergency service:..... # of times used: _____ Name of Service: _____

ENCOUNTER

Encounter Date*: _____

Encounter Location Type*

- ☐ Place Not Meant for Habitation
☐ Service Setting: Non-Residential
☐ Service Setting: Residential

PIT Region Where Slept Last Night***Maui County**

- ☐ **Maui** R1: Central Maui
☐ **Maui** R2: Lower Waiehu
☐ **Maui** R3: Up Country
☐ **Maui** R4: Lahaina
☐ **Maui** R5: Kihei
☐ **Maui** R6: Hana

Kauai County

- ☐ **Kauai** R1: West
☐ **Kauai** R2: South
☐ **Kauai** R3: South Central
☐ **Kauai** R4: East
☐ **Kauai** R5: North

Hawaii County

- ☐ **Hawaii** R1: North Kohala
☐ **Hawaii** R2: Hamakua
☐ **Hawaii** R3: North Hilo
☐ **Hawaii** R4: South Hilo
☐ **Hawaii** R5: Puna
☐ **Hawaii** R6: Kau
☐ **Hawaii** R7: South Kona
☐ **Hawaii** R8: North Kona
☐ **Hawaii** R9: South Kohala

Where did you sleep last night? (Actual location. Please do not enter generic locations, e.g., park, beach, tent, car, street, etc.)*

Actual Location of Encounter* _____

Services Provided (select all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Benefits application assistance | <input type="checkbox"/> Health education/Lifestyle | <input type="checkbox"/> Mail pickup |
| <input type="checkbox"/> Budgeting/Money Management | <input type="checkbox"/> Housing/Shelter enrollment assistance | <input type="checkbox"/> Translation services |
| <input type="checkbox"/> Case management | <input type="checkbox"/> ID assistance | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Food provision | | |

Referrals (select all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Acute/Urgent care | <input type="checkbox"/> Legal services | <input type="checkbox"/> Substance use treatment |
| <input type="checkbox"/> Dental/Vision services | <input type="checkbox"/> Mental health services | <input type="checkbox"/> TB screening |
| <input type="checkbox"/> Educational services | <input type="checkbox"/> Permanent housing | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Employment assistance | <input type="checkbox"/> Primary health services | <input type="checkbox"/> Veterans assistance |

Please provide the exact GPS coordinates of where this encounter interview took place in decimal format to six decimal places:
 (e.g., Latitude: 21.993230, Longitude: -159.342046)

Latitude* _____

Longitude* _____

After manually entering the Latitude/Longitude data into the HMIS, DO NOT CLICK ON THE GEO TRACKING BUTTON.
 Please verify that this location accurately represents where the encounter interview took place and not the location of data entry.