

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 refused  
 Data Not Collected

First Name\*: \_\_\_\_\_ Last Name\*: \_\_\_\_\_

Middle Name: \_\_\_\_\_ Suffix \_\_\_\_\_ Deceased Date \_\_\_\_\_

Birth Date\*: \_\_\_\_\_  Full DOB  Partial (DD/YY)  Client Refused  
 Partial (MM/YY)  Client Doesn't Know  Data Not Collected Age: \_\_\_\_\_

Social Security#\*: \_\_\_\_\_  Full  Partial  Client Refused  
 Client Doesn't Know  Data Not Collected

Gender\*  Male  Gender Non-Conforming (not exclusively male or female)  
 Female  Client Doesn't Know  
 Trans Female (MTF or Male to Female)  Client Refused  
 Trans Male (FTM or Female to Male)  Data Not Collected

Citizenship Status  U.S. Citizen  U.S. National (American Samoa or Swains Island)  Client Doesn't Know  
 Eligible Non-Citizen  Client Refused  
 Non-US Citizen COFA  Ineligible Non-Citizen  Data Not Collected  
 Undocumented

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 Refused  
 Palau  Data Not Collected

Relations to HOH\*  Self (H of H)  Guardian  Veteran Status\*  Client Doesn't Know  
 Spouse  Grandchild  No  Client Refused  
 Child  Other Relative  Yes  Data Not Collected  
 Step Child  Other Non-Relative  
 Foster Child  Unknown  
 Grandparent

Race\* (Select all that apply)  
 American Indian or Alaska Native  White  
 Asian  Client Doesn't Know  
 Black/African American  Refused  
 Native Hawaiian/Other Pacific Islander  Data Not collected

**Ethnicity\* (Select One)**  
 Non-Hispanic or Latino  Client Doesn't Know  
 Hispanic or Latino  Client Refused  
 Data Not Collected  
*(Hispanic/Latino ethnicity refers to Cuban, Mexican, Puerto Rican, South/Central American or other Spanish culture of origin, regardless of race.)*





**HUD Universal Data - LIVING SITUATION (Continued)**

**B. If INSTITUTIONAL situation selected above, answer these questions: (if not, skip to next question)**

Did you stay less than 7 nights?\*  Yes  No

If no, what was the **Length of Stay in the Prior Living Situation\***

- 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
- Data not collected

If yes, what was the **Length of Stay in the Prior Living Situation\***

- 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

If yes, on the night before, **did you stay on the "streets", ES or SH?\***  Yes  No

Approximate date homelessness started\* \_\_\_\_\_

If **"Yes"** (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\*

- Never in 3 years
- One time
- Two times
- Three times
- Four or more times
- Client doesn't know
- Client refused
- Data not collected

If **"Yes"**, Total **number of months** homeless on the streets, in ES, or SH in the past three years\*

- One month (This is the 1st month)
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- More than 12
- Client doesn't know
- Client refused
- Data not collected

**C. If TRANSITIONAL AND PERMANENT HOUSING situation selected, answer these questions: (if not, skip to HUD Program)**

Did you stay less than 7 nights?\*  Yes  No

If no, what was the **Length of Stay in the Prior Living Situation\***

- 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
- Data not collected

If yes, what was the **Length of Stay in the Prior Living Situation\***

- One night or less
- Two to six nights

If yes, on the night before, **did you stay on the "streets", ES or SH?\***  Yes  No

Approximate date homelessness started\* \_\_\_\_\_

If **"Yes"** (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\*

- Never in 3 years
- One time
- Two times
- Three times
- Four or more times
- Client doesn't know
- Client refused
- Data not collected

If **"Yes"**, Total **number of months** homeless on the streets, in ES, or SH in the past three years\*

- One month (This is the 1st month)
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- More than 12
- Client doesn't know
- Client refused
- Data not collected

**HUD Program Data**

**Domestic violence – Domestic violence victim/survivor\***

- No
- Yes
- Client doesn't know
- Client Refused
- Data not collected

**If yes, when experience occurred\***

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

**Are you currently fleeing?\***

- No
- Yes
- Client doesn't know
- Client Refused
- Data not collected

**HUD Program Data (continued)**

**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 Refused    Data not collected

**If yes, please mark all that are applicable:**

- |   |   |
|---|---|
| <input type="checkbox"/> SNAP (Previously known as Food Stamps)     | <input type="checkbox"/> Other TANF-Funded Services                                 |
| <input type="checkbox"/> WIC-Nutrition for Women, Infants, Children | <input type="checkbox"/> Section 8, Public Housing, Other Ongoing Rental Assistance |
| <input type="checkbox"/> TANF Child Care Services                   | <input type="checkbox"/> Temporary Rental Assistance                                |
| <input type="checkbox"/> TANF Transportation Services               | <input type="checkbox"/> Other source: Specify _____                                |

**Health Insurance\*** Are you covered by health insurance?

- No    Yes    Client doesn't know    Client Refused    Data not collected

**Disabling Condition\***

**Substance Abuse\*** (If "NO" selected, skip to Mental Health)

- No    Alcohol Abuse    Drug Abuse  
 Both Alcohol and Drug Abuse    Client doesn't know    Client Refused    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 Refused    Data not collected

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

- No    Yes    Client doesn't know    Client Refused    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 Refused    Data not collected

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

- No    Yes    Client doesn't know    Client Refused    Data not collected

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

- No    Yes    Client doesn't know    Client Refused    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 Refused    Data not collected

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

- No    Yes    Client doesn't know    Client Refused    Data not collected

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

- No    Yes    Client doesn't know    Client Refused    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 Refused    Data not collected

**Health Insurance Assessment (if yes to health insurance)**

- |   |  |
|---|--|
| <input type="checkbox"/> Medicaid                                     | <input type="checkbox"/> Health Insurance obtained through Cobra |
| <input type="checkbox"/> Medicare                                     | <input type="checkbox"/> State Health Insurance for Adults       |
| <input type="checkbox"/> State Children's Health Insurance            | <input type="checkbox"/> Private Pay Health Insurance            |
| <input type="checkbox"/> VA-Veteran's Administration Medical Services | <input type="checkbox"/> Indian Health Services Program          |
| <input type="checkbox"/> Employer-Provided Health Insurance           | <input type="checkbox"/> Other: Specify _____                    |

**HUD Financial Assessment**

Area Median Income\*  Big Island  Kauai  Maui

Income from Any Source\*  No  Yes  Client doesn't know  Client Refused  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:	\$ _____	<b>TOTAL INCOME:</b>	\$ _____

**Hawaii Specific Assessment**

**Hawaii Residence Information**

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

No  Yes  Client doesn't know  Client Refused

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 18<sup>th</sup> 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 refused

**Personal Information**

Marital Status\*:

Single/never married  Married  Widowed  Client refused  
 Living with partner  Separated/divorced  Other \_\_\_\_\_

What is your current criminal justice status\*

Parole  Formerly in system & completed requirements  Client doesn't know  
 Probation  Drug court  Client refused  
 Supervised release  None  Data not collected  
 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 refused

If currently working, # hours worked in past week? \_\_\_\_\_

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

Aloha United Way  Homeless services agency  Self  Client doesn't know  
 Criminal justice  Hospital  VA  Other \_\_\_\_\_

If homeless service agency, which one?\* \_\_\_\_\_

**Hawaii Specific Assessment (continued)**

**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: \_\_\_\_\_