

Enrollment Entry Date\*: \_\_\_\_\_ Program\*: \_\_\_\_\_

**Hawaii HMIS Add New Client: Identifying**

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

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

Middle Name: \_\_\_\_\_ Suffix \_\_\_\_\_

Birth Date\*: \_\_\_\_\_  Full DOB  Partial (DD/YY)  Client doesn't know  Prefers not to answer  
 Data not collected Age: \_\_\_\_\_

Social Security#\*: \_\_\_\_\_  Full  Partial  Client prefers not to answer  
 Client doesn't know  Data not collected

Sex\*  Male  Client doesn't know **Gender**  
 Female  Prefers not to answer  Man (Boy, if child)  Non-Binary  
 Data not collected  Woman (Girl, if child)  Client doesn't know  
 Transgender  Client Refused  
 Questioning  Data not collected

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

Primary Language\*  Chinese  Korean **If Non-US Citizen COFA\***  Pohnpei-Micronesia  
 Chuukese  Marshallese  Chuuk-Micronesia  Yap-Micronesia  
 English  Spanish  Kosrae-Micronesia  Client doesn't know  
 Ilocano  Tagalog  Marshall Islands  Client Refused  
 Japanese  Vietnamese  Palau  Data not collected  
 Other: \_\_\_\_\_

Relationship to HOH\*  Child  Other Relative  
 Step Child  Other Non-Relative  
 Foster Child  Unknown  
 Grandchild

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/Latin(a)(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 \_\_\_\_\_

If Native Hawaiian/Other Pacific Islander chosen above\*  
 Native Hawaiian  Marshallese  Samoan  Tongan  
 Guamanian/Chamorro  Micronesian  Other Pacific Islander \_\_\_\_\_

**Hawaii HMIS Add New Client: Identifying (Continued)**

**What race do you identify with most?\***

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> American India/Alaskan Native | <input type="checkbox"/> Guamanian/Chamorro | <input type="checkbox"/> Micronesian            | <input type="checkbox"/> Tongan              |
| <input type="checkbox"/> Asian Indian                  | <input type="checkbox"/> Native Hawaiian    | <input type="checkbox"/> Other Asian            | <input type="checkbox"/> Vietnamese          |
| <input type="checkbox"/> Black/African American        | <input type="checkbox"/> Japanese           | <input type="checkbox"/> Other Pacific Islander | <input type="checkbox"/> White               |
| <input type="checkbox"/> Chinese/Taiwanese             | <input type="checkbox"/> Korean             | <input type="checkbox"/> Portuguese             | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Filipino                      | <input type="checkbox"/> Marshallese        | <input type="checkbox"/> Samoan                 | <input type="checkbox"/> Client refused      |
|  |   |   | <input type="checkbox"/> Data not collected  |

**Other Information - CONSENT**

**\*\*Minor Children cannot give consent. Consent will be based on the Head of Household\*\***

**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

**HUD Program Data**

**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

**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"/> Veteran’s Health Administration (VHA) | <input type="checkbox"/> Indian Health Services Program          |
| <input type="checkbox"/> Employer-Provided Health Insurance    | <input type="checkbox"/> Other: Specify _____                    |

**HUD RHY Data Assessment** *(\*for BCP ES programs only)*

**Date of Status Determination\*** \_\_\_\_\_

Youth Eligible for RHY\*     No     Yes

If “Yes”, is youth Runaway

- |                             |   |  |
|-----------------------------|---|--|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes            | <input type="checkbox"/> Client doesn’t know |
|                             | <input type="checkbox"/> Client Refused | <input type="checkbox"/> Data not collected  |

If “No”, reason why services not funded by BCP grant

- |  |                                |
|--|--------------------------------|
| <input type="checkbox"/> Out of age range  | <input type="checkbox"/> Other |
| <input type="checkbox"/> Ward of the State – Immediate Reunification                   |                                |
| <input type="checkbox"/> Ward of the Criminal Justice System – Immediate Reunification |                                |