

Arizona Balance of State HMIS



HMIS Intake Form

1. Client Information																														
Client Name and/or Alias		Name Data Quality	<input type="checkbox"/> Full Name Reported <input type="checkbox"/> Partial, Street Name, or Code Name Reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected																											
SSN	_____ - _____ - _____	SSN Data Quality	<input type="checkbox"/> Full SSN Reported <input type="checkbox"/> Approximate or Partial SSN Reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected																											
Client ID		U.S. Military Veteran	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected																											
2. Household Information																														
Household Type	<input type="checkbox"/> Extended Family Unit <input type="checkbox"/> Couple with no children <input type="checkbox"/> Two Parent Family	<input type="checkbox"/> Female Single Parent <input type="checkbox"/> Male Single Parent <input type="checkbox"/> Foster Parent(s)	<input type="checkbox"/> Non-Custodial Caregiver(s) <input type="checkbox"/> Grandparent(s) and Child <input type="checkbox"/> Other																											
Head of Household	<input type="checkbox"/> Yes <input type="checkbox"/> No	If No, HOH Name and ID																												
Relationship to Head of Household	<input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Mother <input type="checkbox"/> Father	<input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Step-Daughter <input type="checkbox"/> Step-Son	<input type="checkbox"/> Grandfather <input type="checkbox"/> Grandmother <input type="checkbox"/> Granddaughter <input type="checkbox"/> Grandson <input type="checkbox"/> Other Relative <input type="checkbox"/> Other Non-Relative <input type="checkbox"/> Significant Other <input type="checkbox"/> Unknown																											
3. Entry Summary																														
Provider Name		Entry Type	<input type="checkbox"/> HUD/Other <input type="checkbox"/> VA <input type="checkbox"/> PATH <input type="checkbox"/> RHY																											
Entry Date	Month Day Year	All Household Members Entering	<input type="checkbox"/> Yes <input type="checkbox"/> No																											
4. Universal Data Elements																														
Relationship to Head of Household	<input type="checkbox"/> Self (Head of Household) <input type="checkbox"/> Head of Household's child <input type="checkbox"/> Head of Household's spouse or partner <input type="checkbox"/> Head of Household's other relation member <input type="checkbox"/> Other: non-relation member <input type="checkbox"/> Data Not Collected	Date of Birth	Month Day Year																											
		DOB Type	<input type="checkbox"/> Full DOB Reported <input type="checkbox"/> Partial DOB Reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected																											
Race	<table border="0"> <tr><td>Pri</td><td>Sec</td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>American Indian/Alaska Native</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Asian</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Black or African-American</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Native Hawaiian/Pacific Islander</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>White</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Client Doesn't Know</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Client Refused</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Data Not Collected</td></tr> </table>	Pri	Sec		<input type="checkbox"/>	<input type="checkbox"/>	American Indian/Alaska Native	<input type="checkbox"/>	<input type="checkbox"/>	Asian	<input type="checkbox"/>	<input type="checkbox"/>	Black or African-American	<input type="checkbox"/>	<input type="checkbox"/>	Native Hawaiian/Pacific Islander	<input type="checkbox"/>	<input type="checkbox"/>	White	<input type="checkbox"/>	<input type="checkbox"/>	Client Doesn't Know	<input type="checkbox"/>	<input type="checkbox"/>	Client Refused	<input type="checkbox"/>	<input type="checkbox"/>	Data Not Collected	Ethnicity	<input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected
Pri	Sec																													
<input type="checkbox"/>	<input type="checkbox"/>	American Indian/Alaska Native																												
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<input type="checkbox"/>	<input type="checkbox"/>	Client Refused																												
<input type="checkbox"/>	<input type="checkbox"/>	Data Not Collected																												
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Transgender Female to Male	<input type="checkbox"/> Doesn't identify as Male, Female, or Transgender <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	Does Client have a disabling condition?																											
			<input type="checkbox"/> Yes <input type="checkbox"/> No																											
Primary Reason Homeless	<input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Bad Credit <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client NOT homeless <input type="checkbox"/> Client refused <input type="checkbox"/> Criminal Activity <input type="checkbox"/> Divorce <input type="checkbox"/> DV Victim <input type="checkbox"/> Eviction <input type="checkbox"/> Fire/Disaster	<input type="checkbox"/> Health/Safety <input type="checkbox"/> In-Transit <input type="checkbox"/> Loss of Childcare <input type="checkbox"/> Loss of Job <input type="checkbox"/> Loss of Public Assistance <input type="checkbox"/> Loss of Trans. <input type="checkbox"/> Medical Condition <input type="checkbox"/> Mortgage Foreclosure <input type="checkbox"/> No Affordable Housing <input type="checkbox"/> Other <input type="checkbox"/> Overcrowding/Family Dispute	<input type="checkbox"/> Physical/Mental Disability <input type="checkbox"/> Poor Budgeting <input type="checkbox"/> Release from Institution <input type="checkbox"/> Release from Jail/Prison <input type="checkbox"/> Release from Mental Health Facility <input type="checkbox"/> Substance Abuse/Addiction <input type="checkbox"/> Substandard Housing <input type="checkbox"/> Unable to Pay Rent/Mortgage <input type="checkbox"/> Underemployment/Low Income <input type="checkbox"/> Utility Shutoff																											

		Residence Prior To Project Entry				
<p>Homeless Situation</p> <p><input type="checkbox"/> Place not meant for habitation</p> <p><input type="checkbox"/> Emergency shelter <i>(Including hotel/motel paid for with Emergency Shelter voucher)</i></p> <p><input type="checkbox"/> Safe Haven</p> <p><input type="checkbox"/> <i>Interim Housing</i></p> <p><input type="checkbox"/> Client doesn't know</p> <p><input type="checkbox"/> Client refused</p> <p><input type="checkbox"/> Data not collected</p>		<p>Institutional Situation</p> <p><input type="checkbox"/> Foster care home or foster care group home</p> <p><input type="checkbox"/> Hospital or other residential non-psychiatric medical facility</p> <p><input type="checkbox"/> Jail, prison, or juvenile detention facility</p> <p><input type="checkbox"/> Psychiatric hospital or other psychiatric facility</p> <p><input type="checkbox"/> Substance abuse treatment facility or detox center</p>		<p>Transitional and Permanent Housing Situation</p> <p><input type="checkbox"/> Hotel or motel paid for without Emergency Shelter voucher</p> <p><input type="checkbox"/> Owned by client, no ongoing subsidy</p> <p><input type="checkbox"/> Owned by client, with ongoing subsidy</p> <p><input type="checkbox"/> Permanent housing for formerly homeless persons</p> <p><input type="checkbox"/> Rental by client, no ongoing subsidy</p> <p><input type="checkbox"/> Rental by client, with VASH subsidy</p> <p><input type="checkbox"/> Rental by client, with GPD TIP subsidy</p> <p><input type="checkbox"/> Rental by client, with other ongoing subsidy</p> <p><input type="checkbox"/> Residential project or halfway house with no homeless criteria</p> <p><input type="checkbox"/> Staying or living in a family member's room, apartment, or house</p> <p><input type="checkbox"/> Staying or living in a friend's room, apartment, or house</p> <p><input type="checkbox"/> Transitional housing for homeless persons (including homeless youth)</p>		
<p>Length of stay in previous place</p> <p><input type="checkbox"/> One night or less</p> <p><input type="checkbox"/> Two to six nights</p> <p><input type="checkbox"/> One week or more, but less than one month</p> <p><input type="checkbox"/> One month or more, but less than 90 days</p> <p><input type="checkbox"/> 90 days or more, but less than one year</p> <p><input type="checkbox"/> One year or longer</p> <p><input type="checkbox"/> Client doesn't know</p> <p><input type="checkbox"/> Client refused</p> <p><input type="checkbox"/> Data Not Collected</p>		<p>Did you stay less than 90 days?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>		<p>If yes, indicate how long they stayed</p> <p><input type="checkbox"/> One night or less</p> <p><input type="checkbox"/> Two to six nights</p> <p><input type="checkbox"/> One week or more, but less than one month</p> <p><input type="checkbox"/> One month or more, but less than 90 days</p>		
		<p>Did you stay less than 7 nights?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>		<p>If yes, indicate how long they stayed</p> <p><input type="checkbox"/> One night or less</p> <p><input type="checkbox"/> Two to six nights</p> <p><input type="checkbox"/> One week or more, but less than one month</p> <p><input type="checkbox"/> One month or more, but less than 90 days</p>		
		<p>On the night before did you stay on the streets, in ES, or SH?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>				
<p>For Chronic Homelessness Determination</p>	<p>(Regardless of where they stayed last night) Total number of times homeless on the street, in Emergency Shelter or SH in the past three years, including today</p>	<p>Approximate date homelessness started</p> <p>Month Day Year</p>				
		<p>Total number of months homeless on the street, in ES, or SH in the past three years</p> <p><input type="checkbox"/> One time <input type="checkbox"/> Two times <input type="checkbox"/> Three times <input type="checkbox"/> Four or more times <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data Not Collected</p>		<p><input type="checkbox"/> One month (this is the first time) <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> More than 12 months <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data Not Collected</p>		
<p>Zip Code of Last Know Permanent Address</p>				<p>Client Location</p> <p><input type="checkbox"/> AZ-500</p>		

5. Program Data Elements						
Income and Benefits						
Total Monthly Income						
Income from any source	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	Non-cash benefit from any source	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	
Sources and Amounts of Income at Entry			Non-Cash Benefits			
Alimony or Other Spousal Support	\$.00	Supplemental Nutrition Assist Program (<i>Food Stamps</i>) <input type="checkbox"/> Special Supplemental Nutrition Program for WIC <input type="checkbox"/> TANF Child Care Services <input type="checkbox"/> TANF Transportation Services <input type="checkbox"/> Other TANF-Funded Services <input type="checkbox"/> Section 8, Public Housing <input type="checkbox"/> Other Source <input type="checkbox"/> Temporary Rental Assistance <input type="checkbox"/>			
Child Support	\$	.00			
Earned Income	\$	.00			
General Assistance	\$	.00			
No Financial Resources	\$	.00			
Other	\$	.00			
Pension or Retirement Former Job	\$	.00			
Private Disability Insurance	\$	.00			
Retirement Income Social Security	\$	.00			
SSDI	\$	.00			
SSI	\$	.00			
TANF	\$	.00			
Tribal Pay	\$	.00			
Unemployment Insurance	\$	.00			
VA Non-Service Disability Pension	\$	.00			
VA Service Connected Disability Comp	\$	.00			
Worker's Compensation	\$	.00			
If Other, Specify _____	\$	.00			
Health Insurance						
Covered by Health Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected		Health Insurance Type	<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Veteran's Administration (VA) Medical Services <input type="checkbox"/> Employer Provided Health Insurance <input type="checkbox"/> Health Insurance obtained through COBRA <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Indian health services program <input type="checkbox"/> Other (Specify) _____		
Disabilities						
Alcohol Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Disability Determination	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	
If Yes, Documentation of disability & severity on file	<input type="checkbox"/> Yes <input type="checkbox"/> No		Currently receiving services or treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	
Chronic Health Condition						
Chronic Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Disability Determination	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	
If Yes, Documentation of disability & severity on file	<input type="checkbox"/> Yes <input type="checkbox"/> No		Currently receiving services or treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	

Developmental		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Disability Determination	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected
If Yes, Documentation of disability & severity on file	<input type="checkbox"/> Yes <input type="checkbox"/> No	Currently receiving services or treatment	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected
Drug Abuse			
Drug Abuse		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Disability Determination	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected
If Yes, Documentation of disability & severity on file	<input type="checkbox"/> Yes <input type="checkbox"/> No	Currently receiving services or treatment	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected
Mental Health Problem			
Mental Health Problem		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Disability Determination	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected
If Yes, Documentation of disability & severity on file	<input type="checkbox"/> Yes <input type="checkbox"/> No	Currently receiving services or treatment	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected
Physical			
Physical		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Disability Determination	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected
If Yes, Documentation of disability & severity on file	<input type="checkbox"/> Yes <input type="checkbox"/> No	Currently receiving services or treatment	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected
HIV/AIDS			
HIV/AIDS		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Disability Determination	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected
If Yes, Documentation of disability & severity on file	<input type="checkbox"/> Yes <input type="checkbox"/> No	Currently receiving services or treatment	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected

Domestic Violence					
Domestic Violence victim/survivor	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	If Yes for Domestic Violence victim/survivor, are you currently fleeing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected
If Yes for Domestic Violence victim/survivor, when experience occurred	<input type="checkbox"/> Within the past three months <input type="checkbox"/> Three to six months ago <input type="checkbox"/> From six months to twelve months ago <input type="checkbox"/> More than one year ago		<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected		
Education					
Currently in School or Working on any Degree?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	Received Vocational Training?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected
Highest Level of Education Attained	<input type="checkbox"/> No Schooling Completed <input type="checkbox"/> Nursery School to 4 th Grade <input type="checkbox"/> 5 th or 6 th Grade <input type="checkbox"/> 7 th or 8 th Grade <input type="checkbox"/> 9 th Grade <input type="checkbox"/> 10 th Grade <input type="checkbox"/> 11 th Grade <input type="checkbox"/> 12 th Grade, No Diploma <input type="checkbox"/> High School Diploma <input type="checkbox"/> GED		<input type="checkbox"/> Post-Secondary School <input type="checkbox"/> Associates Degree <input type="checkbox"/> Bachelors Degree <input type="checkbox"/> Masters Degree <input type="checkbox"/> Doctorate Degree <input type="checkbox"/> Other Graduate/Professional Degree <input type="checkbox"/> Certificate of advanced learning or skilled artisan <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		

Intake Staff Name _____

Release of Information Signed Yes No