

*Team Name: _____

Complete one intake for each family member and child. Complete only * items for each child.



*Intake Date: ____/____/____

Outreach HMIS Intake Form

*First Name	Middle	*Last Name	Jr/Sr	Nickname/Alias
<small>Self / Child / Spouse or Partner / Other Non-Relative</small>				
*Social Security Number	*Birth Date	Age	*Relationship to Head of Household	
<small>F / M / Transgender / Questioning / Gender other than singularly M or F</small>			<small>Heterosexual / Gay / Lesbian / Bisexual / Questioning or Unsure</small>	
*Gender			*Sexual Orientation	

Background Information

Best Phone No.: _____ Email Address: _____

*Ethnicity (check one) Hispanic/Latino(a) Non-Hispanic/Non-Latino Client doesn't know Client refused
(x)

*What Race BEST describes you? (circle all that apply)
[Those of Latin heritage should mark American Indian if their ancestry is from North, South or Central America. Those from the Far East (including India) should mark Asian. Those from the Middle East should mark White.]

American Indian/Alaskan Native Black/African American Client doesn't know Client refused
 Asian White Native Hawaiian/Pacific islander

Have you ever served in the US Military? Yes / No
 If yes, Branch of the Military? (Circle one)
 Army Navy Airforce Marines Coast Guard

Year entered military service: _____ Year separated from military service: _____

Era (check all that apply): World War II Persian Gulf War Iraq Dawn
 Korean War Afghanistan Other Peace-keeping Operations
 Vietnam War Iraq Freedom

Discharge Status: Honorable Bad Conduct Client Refused
 General under honorable conditions Dishonorable
 Other than honorable (OTH) Uncharacterized/Other Client doesn't know

*Present Living Situation (circle one):
 Emergency shelter, including hotel or motel paid for with emergency shelter voucher Place not meant for habitation including non-housing service site Other: _____

If place not meant for habitation, specify below:
 Street/sidewalk Park
 Car Abandoned building
 RV / Camper Bus/train station
 Does the car or RV work? Under a bridge /overpass
 Y or N Outdoor encampment/ woods

*Length of present living situation (circle one):
 One night or less One month or more, but less than 90 days Client doesn't Know
 Two nights to six nights 90 Days or more, but less than one year Client refused
 One week or more, but less than one month One year or longer

*If less than 30 days, where were you living before? (See choices under Present Living Situation) _____

*Approximate date CURRENT episode of homelessness started (breaks of less than 7 days are acceptable) ____ / ____ / ____

*Number of times you have been homeless on the streets/shelter in the PAST THREE YEARS including today: _____

*Total Number of Months Homeless in the PAST THREE YEARS [Note: Any single day or part of a month spent homeless should be counted as 1 month. Short breaks are acceptable]: _____ months

*City where you lost stable housing _____ *Zip code where you lost stable housing _____

*City Slept In Last Night: _____

Is this your first time experiencing homelessness (being without housing)? Yes / No

Total length of time client has been homeless or without housing in lifetime _____ Years and _____ Months

Housing Status at Program Entry

- Category 1 – Homeless (i.e. streets, shelter, transitional housing) Category 3 – Homeless only under other federal statutes At risk of homelessness
 Category 2 – At imminent risk of losing housing (within 14 days) Category 4 – Fleeing domestic violence Stably Housed

Cause of homelessness? (check all that apply)

- Divorce/Separation Domestic violence Eviction
 Loss of job Low income /Underemployment Mental health
 Parole Ran away Rent increase
 Substance abuse Thrown out Other: _____
 Physical health

How did you hear about CORE Outreach? _____

What brought you to this city? (check one)

- I grew up here Just passing through Just released from local hospital ER
 Family/friends live here My services are here (i.e., doctor, MH, PO Box, Foodbank, church) Just released from Psych Emergency
 This city is all I know Just released from local detention facility Other: _____
 Public transport is where I sleep

Were you released as a result of AB109? Yes / No **Domestic Violence Victim/Survivor?** Yes / No
Are you currently on probation? Yes / No **If Yes, when last occurred?** _____
Are you currently on Parole? Yes / No **Are you currently fleeing?** Yes / No
PES Referral? Yes / No **Jail Referral?** Yes / No **CoCo LEAD+ Referral?** Yes / No

Employed? Yes **If Yes, what type?** Full Time Part Time Seasonal (including Day Labor)
 No **If No, why not?** Looking for work Unable to work Not Looking for Work

Have you ever willingly performed or been threatened, coerced, or manipulated to perform a sexual act in exchange for money/goods? Yes / No
Have you ever been threatened, coerced, or manipulated to work without pay? Yes / No
Former Foster Youth? Yes / No

Monthly Income

Income from Any Source? Yes No If yes, write the monthly amounts below

Earned Income	\$	SSDI	\$	TANF	\$
Unemployment Insurance	\$	SSI	\$	GA	\$
Workers Compensation	\$	Retirement Income from Social Security	\$	Alimony Spousal Support	\$
Private Disability Insurance	\$	VA Non-Service Connected Disability	\$	Child Support	\$
VA Service-Connected Disability	\$	Pension or Retirement from a Former Job	\$	Other (Specify):	\$

Non Cash Benefits

Receiving Non Cash Benefits? Yes No If yes, check all that apply

SNAP Supplemental Nutrition Assistance Program (Food Stamps) TANF Childcare Services Other TANF- Funded Services
 WIC Special Supplemental Nutrition Program for Women, Infants, & Children TANF Transportation Services Other (Specify): _____

Health Insurance

Covered by Health Insurance? Yes No If yes, check all that apply

Medicaid VA Medical Private Pay Health Insurance Other Health Insurance
 Medicare Employer-Provided Health Insurance State Health Insurance for Adults Specify Other:
 State Children's Health Insurance Program COBRA Indian Health Services Program

***Disabilities: Please circle Yes or No for EACH of the following**

Physical	Yes / No	Long Term?: Yes / No	Mental health problem	Yes / No	Long Term?: Yes / No
Developmental	Yes / No		Alcohol abuse	Yes / No	Long Term?: Yes / No
Chronic health condition	Yes / No	Long Term?: Yes / No	Drug abuse	Yes / No	Long Term?: Yes / No
HIV/AIDS	Yes / No		Both Alcohol and Drug Abuse	Yes / No	Long Term?: Yes / No

***Do you have a Disabling Condition?** This means: Do you have a condition of expected long duration that substantially limits your ability to live on your own
 Yes No Client doesn't know Client refused

Contact Services Provided (Referral/Placement/Coordination)

Time of Contact: ____ : ____ City of Contact: _____ * Current Living Situation: _____ City Living In: _____ If above is not streets/shelter, is client going to have to leave their living situation within 14 days? Yes / No, If Yes: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> Has a subsequent residence been identified? Yes / No Does client have resources/support networks to obtain other permanent housing? Yes / No Had their own housing unit in last 60 days? Yes / No Moved 2 or more times in last 60 days? Yes / No </div>	Indicate which shelter, facility, center <input type="checkbox"/> Shelter: _____ R / P <input type="checkbox"/> Warming Center (East) <input type="checkbox"/> AOD Treatment : _____ R / P <input type="checkbox"/> Warming Center (West) <input type="checkbox"/> Hospital: _____ R / C <input type="checkbox"/> Sobering Center <input type="checkbox"/> Outpatient Medical : _____ R / C <input type="checkbox"/> DMV <input type="checkbox"/> MH Clinic: _____ R / C <input type="checkbox"/> Medication Pick-Up <input type="checkbox"/> Linkage to HMIOT: _____ <input type="checkbox"/> VASH/SSVF/ <input type="checkbox"/> CARE Center : _____ R / C <input type="checkbox"/> VA Benefit Referral <input type="checkbox"/> Benefits worker – Specify benefits _____ R / C <input type="checkbox"/> Bus/BART Ticket(#): _____ <input type="checkbox"/> HCH Mobile Clinic: _____ R / C <input type="checkbox"/> Animal Services <input type="checkbox"/> Warming Center: _____ R / P <input type="checkbox"/> Emergency Supplies
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*Living Situation Options: • Hospital • Hotel/Motel • Friend's room/apt • Family members room/apt • Jail/Prison/Juvi • Psych facility • Substance abuse/detox • Nursing home or Board & Care • Rental w/ VASH • Rental w/ RRH subsidy • Rental w/ HCV • Rental w/ other subsidy • Rental no subsidy • Own home no subsidy • Own home w/ subsidy • Perm. Supportive Housing

Emergency Contact Person _____ **Phone No.** _____