

*Intake Date: ____/____/____

Concord Service Center HMIS Intake

Warming Center

Service Center

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

Background Information

***Ethnicity** Hispanic/Latin(o)(a)(x) Non-Hispanic/Non-Latin(o)(a)(x) Client doesn't know Client refused

***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.]

White Black/African American/African Client doesn't know Client refused
 Asian or Asian American American Indian/Alaskan Native/Indigenous 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 Uncharacterized/Other
 Other than honorable (OTH) Client doesn't know

<input type="checkbox"/> Literally homeless	<input type="checkbox"/> Institutional situation	<input type="checkbox"/> Transitional & Permanent housing
<input type="checkbox"/> Place not meant for habitation (vehicle, abandoned bldg, train station/airport, or anywhere outside) <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher <input type="checkbox"/> Safe haven	<input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail, prison, or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center	<input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Host home (non-crisis) <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Permanent housing for formerly homeless persons (other than RRH) <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with Housing Choice Voucher (HCV) (tenant or project based) <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Rental by client, with GPD TIP housing subsidy <input type="checkbox"/> Rental by client, with other housing subsidy (including RRH) <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> Staying or living in a friend's room, apartment or house <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Worker unable to confirm
*Length of living situation prior to entering this program: <input type="checkbox"/> One night or less <input type="checkbox"/> Two nights to six nights <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> One month or more, but less than 90 days <input type="checkbox"/> 90 Days or more, but less than one year <input type="checkbox"/> One year or longer <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	*Length of living situation prior to entering this program: <input type="checkbox"/> One night or less <input type="checkbox"/> Two nights to six nights <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> One month or more, but less than 90 days <input type="checkbox"/> 90 Days or more, but less than one year <input type="checkbox"/> One year or longer <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	*Length of living situation prior to entering this program: <input type="checkbox"/> One night or less <input type="checkbox"/> Two nights to six nights <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> One month or more, but less than 90 days <input type="checkbox"/> 90 Days or more, but less than one year <input type="checkbox"/> One year or longer <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
*Approximate date this episode of homelessness started: ____ / ____ / ____	*If the length of stay above was less than 90 days, did you enter the institution from the streets, Emergency shelter, or Safe Haven? <input type="checkbox"/> Yes <input type="checkbox"/> No *If yes, approximate date this episode of homelessness started: ____ / ____ / ____ Note: If homelessness began prior to institution stay, and the institution stay was less than 90 days the stay also counts as time homeless.	*If the length of stay above was less than 7 nights, did you enter the above housing situation from the streets, Emergency shelter, or Safe Haven? <input type="checkbox"/> Yes <input type="checkbox"/> No * If yes, approximate date this episode of homelessness started: ____ / ____ / ____ Note: If client stayed in a housed situation for less than 7 days, the stay also counts as time homeless.

*** For shelters & street outreach only:** If client is coming from an institution where they stayed more than 90 days or a housed situation where they stayed more than 7 days, then their start date of homelessness would be today's date (Intake Date): **Intake Date:** ____ / ____ / ____

***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 last had 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

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

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

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 disorder	Yes / No	Long Term?: Yes / No
Developmental	Yes / No		Alcohol use disorder	Yes / No	Long Term?: Yes / No
Chronic health condition	Yes / No	Long Term?: Yes / No	Drug use disorder	Yes / No	Long Term?: Yes / No
HIV/AIDS	Yes / No		Both Alcohol and Drug use	Yes / No	Long Term?: Yes / No

Note: Chronic health condition – a diagnosed condition that is more than three months in duration and is either not curable or has residual effects that limit daily living and require adaptation in function or special assistance. Examples include but are not limited to: heart disease, severe asthma, diabetes, arthritis-related conditions, adult onset cognitive impairments (including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive related conditions), severe headache/migraine, cancer, chronic bronchitis, liver condition, stroke, or emphysema.

***Do you have a Disabling Condition?** This means: A condition of expected long duration or substantially impairs independence
 Yes No Client doesn't know Client refused

Dependents

Please list information about all dependent children (under 18 years old) entering program

First and last name	Relationship to HOH	Birth date	SSN #	Gender (M/F)	Ethnicity	Race	Special needs	Health Insurance