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 (MM/YY) ☐ Partial (DD/YY) ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected **Age:** ____

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

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

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

Primary Language*
☐ Chinese ☐ Korean
☐ Chuukese ☐ Marshallese
☐ English ☐ Spanish
☐ Ilocano ☐ Tagalog
☐ Japanese ☐ Vietnamese
Other: _____

If Non-US Citizen COFA*
☐ Chuuk-Micronesia ☐ Pohnpei-Micronesia
☐ Kosrae-Micronesia ☐ Yap-Micronesia
☐ Marshall Islands ☐ Client Doesn't Know
☐ Palau ☐ Client Refused
☐ Data Not Collected

Relations to HOH*
☐ Self (H of H) ☐ Guardian
☐ Spouse ☐ Grandchild
☐ Child ☐ Other Relative
☐ Step Child ☐ Other Non-Relative
☐ Foster Child ☐ Unknown
☐ Grandparent

Veteran Status*
☐ No
☐ Yes
☐ Client Doesn't Know
☐ Client Refused
☐ Data Not Collected

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

Ethnicity* (Select One)
☐ Non-Hispanic or Latino
☐ Hispanic or Latino
☐ Client Doesn't Know
☐ 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.)

Hawaii HMIS Add New Client: Identifying (Continued)

If Asian Chosen Above*
☐ Asian Indian
☐ Chinese/Taiwanese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian _____

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

What race do you identify with most?*
☐ American India/Alaskan Native
☐ Asian Indian
☐ Black/African American
☐ Chinese/Taiwanese
☐ Filipino
☐ Guamanian/Chamorro
☐ Native Hawaiian
☐ Japanese
☐ Korean
☐ Marshallese
☐ Micronesian
☐ Other Asian
☐ Other Pacific Islander
☐ Portuguese
☐ Samoan
☐ Tongan
☐ Vietnamese
☐ White
☐ Client doesn't know
☐ Client refused
☐ Data not collected

Contact Information

Address*: _____

Zip Code*: _____ **Apt. Number:** _____

City: _____ **County:** _____

Country*: _____ **State:** _____

Cell Phone: _____
☐ Primary ☐ Secondary ☐ Tertiary

Home Phone: _____
☐ Primary ☐ Secondary ☐ Tertiary

Email Address: _____

Work Phone: _____
☐ Primary ☐ Secondary ☐ Tertiary

Other Information - CONSENT

Was Consent given to share data? : ☐ Yes ☐ No **(Use HMIS Consent Form)**

Date of Consent: _____

*****All consent forms must be uploaded into the HMIS**

Hawaii Add Family

If more than one adult in household, complete additional adult entry form; if child, complete child form

Hawaii Enrollment Add/Edit

Enrollment Entry Date*: _____

Enrollment Exit Date: DO NOT CHANGE

Program*: _____

Provider*: MATCH PROGRAM NAME
☐ Individual
☐ Family

Case Manager: _____

Question: Type of Encounter

☐ **Contact** (*an interaction between a worker and client designed to engage the client – w/ services and/or referrals*)
- Go to Contact/Encounter Form to record services and referrals provided during outreach

☐ **Initial Client Engagement** *(initial interactive client relationship results in a deliberate client assessment or beginning case plan* – In HMIS, this option allows you to complete an ***entry assessment***

Date of Engagement: _____
(Date a client became engaged by a street outreach project in the development of a plan to address their situation. Only one date of engagement is allowed between project entry and exit.)

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 refused ☐ Data not collected

LIVING SITUATION – Type of Residence Prior to Project Entry (*Select only one answer*)

HOMELESS SITUATION
- ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter
- ☐ Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)
- ☐ Safe Haven (SH)

INSTITUATIONAL SITUATION
- ☐ Foster care home or foster care group home
- ☐ Hospital or other residential non-psychiatric medical facility
- ☐ Jail, prison or juvenile detention facility
- ☐ Long-term care facility or nursing home
- ☐ Psychiatric hospital or other psychiatric facility
- ☐ Substance abuse treatment facility or detox center

TRANSITIONAL AND PERMANENT HOUSING SITUATION
- ☐ Hotel or motel paid for without emergency shelter voucher
- ☐ Owned by client, no ongoing housing subsidy
- ☐ Owned by client, with ongoing housing subsidy
- ☐ Permanent housing (other than RRH) for formerly homeless persons
- ☐ Rental by client, no ongoing housing subsidy
- ☐ Rental by client, with other ongoing housing subsidy (including RRH)
- ☐ Staying or living in a family member's room, apartment or house
- ☐ Staying or living in a friend's room, apartment or house
- ☐ Transitional housing for homeless persons (including homeless youth)
- ☐ Rental by client, with VASH subsidy
- ☐ Rental by client, with GPD TIP subsidy
- ☐ Residential project or halfway house with no homeless criteria
- ☐ Rental by client with RRH or equivalent subsidy
- ☐ Host Home (non-crisis)
- ☐ Rental by client with HCV voucher (tenant or project based)
- ☐ Rental by client in a public housing unit
- ☐ Client doesn't know
- ☐ Client refused
- ☐ Data not collected

Approximate date homelessness started* _____

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
- ☐ 90 days or more, but less than one year
- ☐ One year or longer
- ☐ Client doesn't know
- ☐ Client refused
- ☐ Data not collected

(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

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 your currently fleeing?*

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

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:

☐ SNAP (Previously known as Food Stamps)
☐ WIC-Nutrition for Women, Infants, Children
☐ TANF Child Care Services
☐ TANF Transportation Services
☐ Other TANF-Funded Services
☐ Section 8, Public Housing, Other Ongoing Rental Assistance
☐ Temporary Rental Assistance
☐ 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*)

☐ Medicaid
☐ Medicare
☐ State Children's Health Insurance
☐ VA-Veteran's Administration Medical Services
☐ Employer-Provided Health Insurance
☐ Health Insurance obtained through Cobra
☐ State Health Insurance for Adults
☐ Private Pay Health Insurance
☐ Indian Health Services Program
☐ 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*

Income Type	Amount	Income Type	Amount
☐ Unemployment	$ _____	☐ Retirement from Social Security:	$ _____
☐ Earned Income (employment):	$ _____	☐ VA Non-Service Disability Pension	$ _____
☐ SSI:	$ _____	☐ Pension or Retirement Income (job):	$ _____
☐ SSDI:	$ _____	☐ Child Support:	$ _____
☐ VA Service Disability Compensation:	$ _____	☐ Alimony or Other Spousal Support:	$ _____
☐ Private Disability Insurance:	$ _____	☐ Worker's Compensation:	$ _____
☐ TANF	$ _____	☐ Other:	$ _____
☐ General Assistance:	$ _____	**TOTAL INCOME:**	$ _____

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 18th 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?

_____

Hawaii Specific Assessment (continued)

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?* _____

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:_____

ENCOUNTER

Encounter Date* _____

Encounter Location Type* ☐ Place Not Meant for Habitation ☐ Service Setting: Non-Residential ☐ Service Setting: Residential

PIT Region Where Slept Last Night*

Maui County

☐ **Maui** R1: Central Maui ☐ **Maui** R2: Lower Waiehu ☐ **Maui** R3: Up Country ☐ **Maui** R4: Lahaina ☐ **Maui** R5: Kihei
☐ **Maui** R6: Hana

Kauai County

☐ **Kauai** R1: West ☐ **Kauai** R2: South ☐ **Kauai** R3: South Central ☐ **Kauai** R4: East ☐ **Kauai** R5: North

Hawaii County

☐ **HI** R1: Kohala ☐ **HI** R2: Honokaa ☐ **HI** R3: Laupahoehoe ☐ **HI** R4: Hilo ☐ **HI** R5: Waiakea
☐ **HI** R6: Keaau ☐ **HI** R7: Pahoa ☐ **HI** R8: Kau ☐ **HI** R9: Konawaena ☐ **HI** R10: Kealakehe

Where did you sleep last night?* _____

Actual Location of Encounter* _____

Encounter Location Zip Code* _____

Encounter Section A - General Services:

☐ Benefits application assistance ☐ Health education/lifestyle ☐ Translation services
☐ Budgeting/Money Management ☐ Housing/shelter enrollment assistance ☐ Transportation
☐ Case management ☐ ID assistance
☐ Food provision ☐ Mail pickup

Encounter Section B - Health Referrals:

☐ Acute/Urgent care ☐ Mental health services ☐ Substance use treatment
☐ Dental/Vision services ☐ Primary health services ☐ TB screening

Encounter Section C - Social Service Referrals:

☐ Educational services ☐ Permanent housing
☐ Employment assistance ☐ Transportation
☐ Legal services ☐ Veterans assistance