



MSCCoC_MIS HOPWA Project Start

Community Alliance for the Homeless | Management Information Systems | Tanyce McCray-Davis | MIS Director/System Admin II
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FOR TEXT FIELDS, USE BLOCK LETTERS. OTHERWISE, MARK APPROPRIATE BOXES WITH AN "X". Complete a separate form for each member of the household.

Date of Data Collection

		/			/				
Month			Day			Year			

Client ID

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NAME (first, middle, last name, suffix (e.g., Jr, Sr, III)) [All clients]

First Name:																				
Middle Name:																				
Last Name:																				
Suffix:																				
Alias:																				

Social Security Number: [All clients]

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Date of Birth: (e.g., 10/23/1978) [All clients]

		/			/				
Month			Day			Year			

PRIMARY RACE (MORE THAN ONE RACE IS PERMITTED. (ALL CLIENTS) *PLEASE IDENTIFY THE PRIMARY RACE*

<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> White
<input type="checkbox"/> Asian	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Client refused
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> Other

Ethnicity (All clients)

<input type="checkbox"/> Non-Hispanic / Non-Latino	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Hispanic / Non-Latino	<input type="checkbox"/> Client refused

Gender (All clients)

<input type="checkbox"/> Female	<input type="checkbox"/> Gender Non-Conforming (i.e., not exclusively male or female)
<input type="checkbox"/> Male	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Trans Female (MTF or Male to Female)	<input type="checkbox"/> Client refused
<input type="checkbox"/> Trans Male (FTM or Female to Male)	

Veterans Status (all clients)

<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Yes	<input type="checkbox"/> Client refused

Relationship to Head of Household [All clients]

<input type="checkbox"/>	Self (Head of Household & Singles)	<input type="checkbox"/>	Head of household's other relation to head of household
<input type="checkbox"/>	Head of household's child	<input type="checkbox"/>	Other: non-relation to head of household
<input type="checkbox"/>	Head of household's spouse or partner	<input type="checkbox"/>	Specify Relation: _____

Last Grade Completed/Highest Grade Completed

<input type="checkbox"/>	Less than Grade 5	<input type="checkbox"/>	Associates degree
<input type="checkbox"/>	Grades 5 - 6	<input type="checkbox"/>	Bachelor's degree
<input type="checkbox"/>	Grades 7 - 8	<input type="checkbox"/>	Graduate degree
<input type="checkbox"/>	Grades 9 - 11	<input type="checkbox"/>	Vocational certification
<input type="checkbox"/>	Grade 12 - High School Diploma	<input type="checkbox"/>	
<input type="checkbox"/>	School Program does not have grade levels	<input type="checkbox"/>	Client Doesn't Know
<input type="checkbox"/>	GED	<input type="checkbox"/>	Client Refused
<input type="checkbox"/>	Some College	<input type="checkbox"/>	Data Not Collected

Pregnancy

<input type="checkbox"/>	Are you Pregnant?	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes
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HOMELESS INFORMATION

Residence Prior to Project Entry?

<input type="checkbox"/>	Place not meant for habitation	<input type="checkbox"/>	Emergency shelter, including hotel or motel paid for with emergency shelter voucher	<input type="checkbox"/>	Interim Housing
<input type="checkbox"/>	Foster care home or foster care group home	<input type="checkbox"/>	Jail, prison or juvenile detention facility	<input type="checkbox"/>	Psychiatric hospital or other psychiatric facility
<input type="checkbox"/>	Hospital or other residential non-psychiatric medical facility	<input type="checkbox"/>	Long-term care facility or nursing home	<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"/>	Rental by client, with VASH subsidy	<input type="checkbox"/>	Staying or living in a friend's room, apartment or house
<input type="checkbox"/>	Owned by client, no ongoing housing subsidy	<input type="checkbox"/>	Rental by client, with GPD TIP subsidy	<input type="checkbox"/>	Transitional housing for homeless persons (including homeless youth)
<input type="checkbox"/>	Owned by client, with ongoing housing subsidy	<input type="checkbox"/>	Rental by client, with other ongoing housing subsidy	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Permanent housing for formerly homeless persons (such as: a CoC project; HUD legacy programs; or HOPWA PH)	<input type="checkbox"/>	Residential project or halfway house with no homeless criteria	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Rental by client, no ongoing housing subsidy	<input type="checkbox"/>	Staying or living in a family member's room, apartment or house	<input type="checkbox"/>	Data not collected
<input type="checkbox"/>	VA Medical Referral				

Length of Stay in Prior Living Situation

<input type="checkbox"/>	One night or less	<input type="checkbox"/>	Two to six nights	<input type="checkbox"/>	One week or more, but less than one month
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<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	<input type="checkbox"/>	Data not collected
<input type="checkbox"/>	Unknown				

Approximate date homelessness started:

	/		/			
Month		Day		Year		

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:

<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"/>	Hospital or other residential non-psychiatric medical facility	<input type="checkbox"/>	Long-term care facility or nursing home	<input type="checkbox"/>	Substance abuse treatment facility or detox center

Total number of months homeless on the street, in ES, or SH in the past three years:

<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	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected

DOMESTIC VIOLENCE VICTIM (ALL CLIENTS)

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes
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If Victim of DV - How Long Ago? (All Clients)

<input type="checkbox"/>	1 Day to 3 Months	<input type="checkbox"/>	More than a Year
<input type="checkbox"/>	3 Months to 6 Months	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	6 Months to 1 Year	<input type="checkbox"/>	Client refused

Are you currently fleeing?

<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
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INCOME & SOURCES *PROOF NEEDED*

What is the Household total monthly income?

\$ _____

Have you received income from any source? No Yes

If yes for "Income from any source:

Indicate all sources and dollar amounts for the source that apply:

No	Yes	Source of Income	Amount	No	Yes	Source of Income	Amount
<input type="checkbox"/>	<input type="checkbox"/>	Earned income (i.e. employment income)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Worker's Compensation	\$
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Security Income (SSI)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Temporary Assistance for Needy Families (TANF)	\$
<input type="checkbox"/>	<input type="checkbox"/>	Social Security Disability Income (SSDI)	\$	<input type="checkbox"/>	<input type="checkbox"/>	General Assistance (GA)	\$

<input type="checkbox"/>	<input type="checkbox"/>	VA Service Connected Disability Compensation	\$	<input type="checkbox"/>	<input type="checkbox"/>	VA Non Service Connected Disability Pension	\$
<input type="checkbox"/>	<input type="checkbox"/>	Retirement Income from Social Security	\$	<input type="checkbox"/>	<input type="checkbox"/>	Responses Pension or retirement income from a former job	\$
<input type="checkbox"/>	<input type="checkbox"/>	Private disability insurance	\$	<input type="checkbox"/>	<input type="checkbox"/>	Child support	\$
<input type="checkbox"/>	<input type="checkbox"/>	Unemployment Insurance	\$	<input type="checkbox"/>	<input type="checkbox"/>	Alimony and other spousal support	\$
<input type="checkbox"/>	<input type="checkbox"/>	Other Source (specify	\$				

NON-CASH BENEFITS *PROOF NEEDED*

Have you received non-cash benefits from any source?

<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
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If yes for non-cash benefits from any source and dollar amounts for the source that apply:

No	Yes	Source of Benefit	Amount	No	Yes	Source of Benefit	Amount
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Nutrition Assistance Program (SNAP) (Previously known as Food Stamps)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	\$
<input type="checkbox"/>	<input type="checkbox"/>	SANF Child Care services (or use local name)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Temporary Assistance for Needy Families (TANF)	\$
<input type="checkbox"/>	<input type="checkbox"/>	TANF transportation services (or use local name)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Other TANF unded Services (or use local name)	\$
<input type="checkbox"/>	<input type="checkbox"/>	Section 8, public housing, or other ongoing rental assistance	\$	<input type="checkbox"/>	<input type="checkbox"/>	Temporary rental assistance	\$
<input type="checkbox"/>	<input type="checkbox"/>	Other Source	\$	If yes to "Other" Source, please specify			

DISABILITY INFORMATION *PROOF NEEDED*

Does client have a disability?

<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
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ALCOHOL ABUSE

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:					/		/			
												Month	Day	Year

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<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
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Is there Documentation of the disability and severity on file?

<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
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Currently receiving services/treatment for this disability?

<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
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CHRONIC HEALTH CONDITION

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:					/		/			
												Month	Day	Year

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<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
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Is there Documentation of the disability and severity on file?

<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
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Currently receiving services/treatment for this disability?

<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
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DEVELOPMENTAL DISABILITY

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:					/			/				
								Month		Day		Year				

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<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
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Is there Documentation of the disability and severity on file?

<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
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Currently receiving services/treatment for this disability?

<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
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HIV/AIDS

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:					/			/				
								Month		Day		Year				

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<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
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Is there Documentation of the disability and severity on file?

<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
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Currently receiving services/treatment for this disability?

<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
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MENTAL HEALTH CONDITION

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:					/			/				
								Month		Day		Year				

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<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
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Is there Documentation of the disability and severity on file?

<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
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Currently receiving services/treatment for this disability?

<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
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PHYSICAL CONDITION

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:					/			/				
								Month		Day		Year				

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<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
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Is there Documentation of the disability and severity on file?

<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
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Currently receiving services/treatment for this disability?

<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
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INSURANCE INFORMATION *PROOF NEEDED*

Covered by health insurance?

<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date Information Collected:			/			/				
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HEALTH INSURANCE PROVIDERS

NO	YES		NO	YES	
<input type="checkbox"/>	<input type="checkbox"/>	MEDICAID	<input type="checkbox"/>	<input type="checkbox"/>	Health Insurance obtained through COBRA
<input type="checkbox"/>	<input type="checkbox"/>	MEDICARE	<input type="checkbox"/>	<input type="checkbox"/>	Private Pay Health Insurance
<input type="checkbox"/>	<input type="checkbox"/>	State Children's Health Insurance Program (or use local name)	<input type="checkbox"/>	<input type="checkbox"/>	State Health Insurance for Adults (or use local name)
<input type="checkbox"/>	<input type="checkbox"/>	Veteran's Administration (VA) Medical Services	<input type="checkbox"/>	<input type="checkbox"/>	Indian Health Services Program
<input type="checkbox"/>	<input type="checkbox"/>	Employer - Provided Health Insurance	<input type="checkbox"/>	<input type="checkbox"/>	Other

HIV/AIDS INFORMATION

Start Date (Required)

		/			/				
Month			Day			Year			

End Date

		/			/				
Month			Day			Year			

If Yes for HIV/AIDS, does the client have a T-Cell (CD4) count available?

<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
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If Yes for HIV/AIDS and a T-Cell (CD4) count is available, what is the T-Cell (CD4) count? [integer 0-1500]

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If Yes for HIV/AIDS and a T-Cell (CD4) count is recorded above, how was the information obtained?

<input type="checkbox"/> Medical Report	<input type="checkbox"/> Client Report	<input type="checkbox"/> Other
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If Yes for HIV/AIDS, does the client have Viral Load Information available?

<input type="checkbox"/> Not Available	<input type="checkbox"/> Available	<input type="checkbox"/> Undetectable	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> DNC
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If Yes for HIV/AIDS and Viral Load Information is available, what is the Viral Load? [integer 0-999999]

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Receiving Public HIV/AIDS Medical Assistance

<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
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If not Receiving Public HIV/AIDS Medical Assistance, specify reason

<input type="checkbox"/> Applied; decision pending	<input type="checkbox"/> Applied; Client not eligible	<input type="checkbox"/> Client did not apply
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<input type="checkbox"/>	Insurance type N/A for this client	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client Refused
<input type="checkbox"/>	Data Not Collected				

If Yes for HIV/AIDS and Viral Load is recorded above, how was the information obtained?

<input type="checkbox"/>	Medical Report	<input type="checkbox"/>	Client Report	<input type="checkbox"/>	Other
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Receiving AIDS Drug Assistance Program (ADAP)

<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
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Housing Move In Date:

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