COMMUNITY TECHNOLOGY ALLIANCE

HMIS #:
CM Name:
Project Entry Date:

Monterey & San Benito Counties HMIS
Standardized Intake: Adult Exit

This form is designed to be completed by a service provider while interviewing a client.
A separate Standardized Intake form should be completed for each member of the household.

Household Information

Is client: ❑ Single Adult ❑ Adult in Household

If check Single Adult	Go to Client Profile
If checked Adult in Household	Are you the Head of Household (HoH)? ❑ Yes ❑ No If no, name of HoH: How many adults in household?: How many children in household?:
If checked Child	Name of HoH:
If you are in a household, what is your relationship to the HoH?	❑ Self (head of household) ❑ Head of household's child ❑ Head of household's spouse or partner ❑ Other relation to head of household) ❑ Other: non-relation member

Client Profile

First Name	**Middle**	
Last Name		
Social Security Number		
U.S. Military Veteran	❑ Yes ❑ No	❑ Client Doesn't Know ❑ Client Refused

HMIS #

Reason for Leaving & Destination

Reason for Leaving	❑ Completed Program ❑ Criminal Activity/Violence ❑ Death ❑ Disagreement with rules/persons ❑ Left for housing opportunity ❑ Needs could not be met ❑ Non-compliance ❑ Non-payment of rent ❑ Reach max time allowed ❑ Other ❑ Client Doesn't Know ❑ Client Refused ❑ Unknown/Disappeared
If Other, Specify:	
Destination	❑ Deceased ❑ Emergency shelter ❑ Foster care or foster care group home ❑ Hospital or other non-psychiatric medical facility ❑ Hotel or motel paid for w/o emergency shelter voucher ❑ Jail, prison or juvenile detention facility ❑ Long-term care facility or nursing home ❑ Moved from one HOPWA funded project to HOPWA PH ❑ Moved from one HOPWA funded project to HOPWA TH ❑ Owned by client, no ongoing housing subsidy ❑ Owned by client, with ongoing subsidy ❑ Permanent housing (other than RRH) for formerly homeless persons ❑ Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) ❑ Psychiatric hospital or other psychiatric facility ❑ Rental by client, no ongoing housing subsidy ❑ Rental by client, with RRH or equivalent subsidy ❑ Rental by client, with VASH subsidy ❑ Rental by client, with GDP TIP subsidy ❑ Rental by client, with other ongoing subsidy ❑ Residential project or halfway house with no homeless criteria ❑ Safe Haven ❑ Staying or living with family, permanent tenure ❑ Staying or living with family, temporary tenure ❑ Substance abuse treatment facility or detox center ❑ Transitional housing for homeless persons ❑ Other ❑ No exit interview completed ❑ Client doesn't know ❑ Client refused ❑ Data not collected
If Other, Specify:	

Housing Move-In Date	

HMIS #

Monthly Income – Cash Benefits

Income from any source?	❑ Yes ❑ No ❑ Client doesn't know ❑ Client refused
Total monthly income:	$
❑ Alimony or Other Spousal Income $_____	❑ Retirement income from Social Security $_____
Date start receiving:_____	**Date start receiving:**_____
❑ Child Support $_____	❑ SSDI $_____
Date start receiving:_____	**Date start receiving:**_____
❑ Earned Income $_____	❑ SSI $_____
Date start receiving:_____	**Date start receiving:**_____
❑ General Assistance $_____	❑ TANF $_____
Date start receiving:_____	**Date start receiving:**_____
❑ Other $_____	❑ Unemployment Insurance $_____
Date start receiving:_____	**Date start receiving:**_____
If Other specify: _____	❑ VA Non-service connect disability pension $_____
❑ Pension or retirement from another job $_____	**Date start receiving:**_____
Date start receiving:_____	❑ VA Service connected disability compensation $_____
❑ Private disability insurance $_____	**Date start receiving:**_____
Date start receiving:_____	❑ Worker's compensation $_____
	Date start receiving:_____

Non-Cash Benefits

Income from any source?	❑ Yes ❑ No ❑ Client doesn't know ❑ Client refused
❑ Special supplement nutrition program for WIC	❑ TANF Transportation services$_____
$_____	❑ Other TANF funded services $_____
❑ Supplemental nutrition assistance program (Food Stamps) $_____	❑ Other Source
	If Other, specify:
❑ TANF-Child care services $_____	

HMIS #

Health Insurance

Covered by health insurance?	❑ Yes ❑ No ❑ Client doesn't know ❑ Client refused
❑ Medicaid	❑ Private pay health plan
❑ Medicare	❑ State health insurance for adults
❑ State children's health insurance program	❑ Indian health services program
❑ VA Medical Services	❑ Other Source
❑ Employer provided	If Other, specify:

Disability

Does the client have a disabling condition? ❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused

If Yes, please complete the following for each disability type

Alcohol Abuse ❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused

Disability State Date _____

Condition Long term?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused

Both Alcohol & Drug Abuse ❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused

Disability Start Date _____

Condition Long term?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused

Chronic Health Condition ❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused

Disability Start Date _____

Condition Long term?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused

Developmental ❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused

Disability State Date _____

Condition Long term?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused

HMIS #

Drug Abuse	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	Condition Long term?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Disability Start Date	_____	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
HIV/AIDS	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	Condition Long term?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Disability State Date	_____	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Mental Health Problem	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	Condition Long term?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Disability State Date	_____	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Physical	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	Condition Long term?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Disability State Date	_____	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused

HMIS #

Employment Status

Employed	❑ Yes ❑ Client Doesn't Know ❑ No ❑ Client Refused
If Yes, Type of Employment	❑ Full-time ❑ Part-time ❑ Seasonal/Sporadic (including day labor)
If No, Why Not Employed	❑ Looking for work ❑ Unable to work ❑ Not looking for work

I (Adult client or Head of Household) certify that the information I have provided here is true/correct to the best of my knowledge.

Print Name of Client	Signature of Client	Date
Print Name of Intake Worker	Signature of Intake Worker	Date