MSCCoC_MIS HOPWA Project Start

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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

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]

			-			-				

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

		/			/				

Month Day Year

Veterans Status (all clients)

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused

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

☐	American Indian or Alaskan Native	☐	White
☐	Asian	☐	Client doesn't know
☐	Black or African American	☐	Client refused
☐	Native Hawaiian or Other Pacific Islander	☐	Other

Ethnicity (All clients)

☐	Non-Hispanic / Non-Latino	☐	Client doesn't know
☐	Hispanic / Non-Latino	☐	Client refused

Gender (All clients)

☐	Female	☐	Gender Non-Conforming (i.e., not exclusively male or female
☐	Male	☐	Client doesn't know
☐	Trans Female (MTF or Male to Female)	☐	Client refused
☐	Trans Male (FTM or Female to Male)		

EMERGENCY CONTACT INFORMATION

Contact's Name________________________________ Phone Number ________________________________

Address________________________________ Relationship to Client________________________________

City________________________________ State ________________________________

Start Date									
			-						
Month		Day				Year			

End Date									
		/			/				
Month			Day				Year		

Client Location: TN-501

Relationship to Head of Household [All clients]

☐	Self (Head of Household & Singles)	☐	Head of household's other relation to head of household
☐	Head of household's child	☐	Other: non-relation to head of household
☐	Head of household's spouse or partner	☐	Specify Relation: ____________________

Last Grade Completed/Highest Grade Completed

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

Pregnancy

☐	Are you Pregnant?	☐	No	☐	Yes

HOMELESS INFORMATION

Residence Prior to Project Entry?

☐	Place not meant for habitation	☐	Emergency shelter, including hotel or motel paid for with emergency shelter voucher	☐	Interim Housing
☐	Foster care home or foster care group home	☐	Jail, prison or juvenile detention facility	☐	Psychiatric hospital or other psychiatric facility
☐	Hospital or other residential non-psychiatric medical facility	☐	Long-term care facility or nursing home	☐	Substance abuse treatment facility or detox center
☐	Hotel or motel paid for without emergency shelter voucher	☐	Rental by client, with VASH subsidy	☐	Staying or living in a friend's room, apartment or house
☐	Owned by client, no ongoing housing subsidy	☐	Rental by client, with GPD TIP subsidy	☐	Transitional housing for homeless persons (including homeless youth)
☐	Owned by client, with ongoing housing subsidy	☐	Rental by client, with other ongoing housing subsidy	☐	Client doesn't know

☐	Permanent housing for formerly homeless persons (such as: a CoC project; HUD legacy programs; or HOPWA PH)	☐	Residential project or halfway house with no homeless criteria	☐	Client refused
☐	Rental by client, no ongoing housing subsidy	☐	Staying or living in a family member's room, apartment or house	☐	Data not collected
☐	VA Medical Referral				

Length of Stay in 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
☐	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:

☐	One Time	☐	Two times	☐	Three times
☐	Four or more times	☐	Client doesn't know	☐	Client refused
☐	Hospital or other residential non-psychiatric medical facility	☐	Long-term care facility or nursing home	☐	Substance abuse treatment facility or detox center

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

☐	One month (this is the first time)	☐	2	☐	3	☐	4
☐	5	☐	6	☐	7	☐	8
☐	9	☐	10	☐	11	☐	12
☐	More than 12	☐	Client doesn't know	☐	Client refused	☐	Data not collected

DOMESTIC VIOLENCE VICTIM (ALL CLIENTS)

☐	No	☐	Yes

If Victim of DV - How Long Ago? (All Clients)

☐	1 Day to 3 Months	☐	More than a Year
☐	3 Months to 6 Months	☐	Client doesn't know
☐	6 Months to 1 Year	☐	Client refused

Are you currently fleeing?

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

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
☐	☐	Earned income (i.e. employment income)	$	☐	☐	Worker's Compensation	$
☐	☐	Supplemental Security Income (SSI)	$	☐	☐	Temporary Assistance for Needy Families (TANF)	$
☐	☐	Social Security Disability Income (SSDI)	$	☐	☐	General Assistance (GA)	$
☐	☐	VA Service Connected Disability Compensation	$	☐	☐	VA Non Service Connected Disability Pension	$
☐	☐	Retirement Income from Social Security	$	☐	☐	Responses Pension or retirement income from a former job	$
☐	☐	Private disability insurance	$	☐	☐	Child support	$
☐	☐	Unemployment Insurance	$	☐	☐	Alimony and other spousal support	$
☐	☐	Other Source (specify	$				

NON-CASH BENEFITS *PROOF NEEDED*

Have you received non-cash benefits from any source?

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

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
☐	☐	Supplemental Nutrition Assistance Program (SNAP) (Previously known as Food Stamps)	$	☐	☐	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC	$
☐	☐	SANF Child Care services (or use local name)	$	☐	☐	Temporary Assistance for Needy Families (TANF)	$
☐	☐	TANF transportation services (or use local name)	$	☐	☐	Other TANF unded Services (or use local name)	$
☐	☐	Section 8, public housing, or other ongoing rental assistance	$	☐	☐	Temporary rental assistance	$
☐	☐	Other Source	$	If yes to "Other" Source, please specify			

DISABILITY INFORMATION *PROOF NEEDED*

Does client have a disability?

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

ALCOHOL ABUSE

☐	No	☐	Yes	Date Information Collected:			/			/				
					Month			Day				Year		

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

Is there Documentation of the disability and severity on file?

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

Currently receiving services/treatment for this disability?

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

CHRONIC HEALTH CONDITION

☐	No	☐	Yes	Date Information Collected:			/			/				
					Month			Day				Year		

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

Is there Documentation of the disability and severity on file?

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

Currently receiving services/treatment for this disability?

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

DEVELOPMENTAL DISABILITY

☐	No	☐	Yes	Date Information Collected:			/			/				
					Month			Day				Year		

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

Is there Documentation of the disability and severity on file?

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

Currently receiving services/treatment for this disability?

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

HIV/AIDS

☐	No	☐	Yes	Date Information Collected:			/			/				
					Month			Day				Year		

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

Is there Documentation of the disability and severity on file?

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

Currently receiving services/treatment for this disability?

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

MENTAL HEALTH CONDITION

☐	No	☐	Yes	Date Information Collected:			/			/				
					Month			Day				Year		

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

Is there Documentation of the disability and severity on file?

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

Currently receiving services/treatment for this disability?

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

PHYSICAL CONDITION

☐	No	☐	Yes	Date Information Collected:			/			/				
					Month			Day			Year			

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

Is there Documentation of the disability and severity on file?

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

Currently receiving services/treatment for this disability?

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

INSURANCE INFORMATION *PROOF NEEDED*

Covered by health insurance?

☐	No	☐	Yes	Date Information Collected:			/			/				

HEALTH INSURANCE PROVIDERS

NO	YES		NO	YES	
☐	☐	MEDICAID	☐	☐	Health Insurance obtained through COBRA
☐	☐	MEDICARE	☐	☐	Private Pay Health Insurance
☐	☐	State Children's Health Insurance Program (or use local name)	☐	☐	State Health Insurance for Adults (or use local name)
☐	☐	Veteran's Administration (VA) Medical Services	☐	☐	Indian Health Services Program
☐	☐	Employer – Provided Health Insurance	☐	☐	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?

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

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

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

☐	Medical Report	☐	Client Report	☐	Other

If Yes for HIV/AIDS, does the client have Viral Load Information available?

☐	Not Available	☐	Available	☐	Undetectable	☐	Client doesn't know	☐	Client Refused	☐	DNC

If Yes for HIV/AIDS and Viral Load Information is available, what is the Viral Load? [integer 0-999999]

Receiving Public HIV/AIDS Medical Assistance

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

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

☐	Applied; decision pending	☐	Applied; Client not eligible	☐	Client did not apply
☐	Insurance type N/A for this client	☐	Client doesn't know	☐	Client Refused
☐	Data Not Collected				

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

☐	Medical Report	☐	Client Report	☐	Other

Receiving AIDS Drug Assistance Program (ADAP)

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

Housing Move In Date:

		/			/				