



MSCCoC_MIS HOPWA Project Interim

Community Alliance for the Homeless | Management Information Systems | Tanyce McCray-Davis | MIS Director/System Admin II
 Off. 901-527-1302 | Cell 901-652-2678 | Email: tanyce@cafh.org

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]

		/			/				
--	--	---	--	--	---	--	--	--	--

Client Location TN-501

Housing Move In Date:

		/			/			
Month			Day			Year		

DOMESTIC VIOLENCE VICTIM (ALL CLIENTS)

<input type="checkbox"/> No	<input type="checkbox"/> Yes
-----------------------------	------------------------------

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
-----------------------------	------------------------------	--	---	---

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
--------------------------	----	--------------------------	-----	--------------------------	---------------------	--------------------------	----------------	--------------------------	--------------------

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 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
--------------------------	----	--------------------------	-----	--------------------------	---------------------	--------------------------	----------------	--------------------------	--------------------

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
--------------------------	----	--------------------------	-----	--------------------------	---------------------	--------------------------	----------------	--------------------------	--------------------

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
--------------------------	----	--------------------------	-----	--------------------------	---------------------	--------------------------	----------------	--------------------------	--------------------

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
--------------------------	----	--------------------------	-----	--------------------------	---------------------	--------------------------	----------------	--------------------------	--------------------

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
--------------------------	----	--------------------------	-----	--------------------------	---------------------	--------------------------	----------------	--------------------------	--------------------

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
--------------------------	----	--------------------------	-----	--------------------------	---------------------	--------------------------	----------------	--------------------------	--------------------

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
--------------------------	----	--------------------------	-----	--------------------------	---------------------	--------------------------	----------------	--------------------------	--------------------

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
--------------------------	----	--------------------------	-----	--------------------------	---------------------	--------------------------	----------------	--------------------------	--------------------

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
--------------------------	----	--------------------------	-----	--------------------------	---------------------	--------------------------	----------------	--------------------------	--------------------

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
--------------------------	----	--------------------------	-----	--------------------------	---------------------	--------------------------	----------------	--------------------------	--------------------

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
--------------------------	----	--------------------------	-----	--------------------------	---------------------	--------------------------	----------------	--------------------------	--------------------

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
--------------------------	----	--------------------------	-----	--------------------------	---------------------	--------------------------	----------------	--------------------------	--------------------

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
--------------------------	----	--------------------------	-----	--------------------------	---------------------	--------------------------	----------------	--------------------------	--------------------

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
--------------------------	----	--------------------------	-----	--------------------------	---------------------	--------------------------	----------------	--------------------------	--------------------

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
--------------------------	----	--------------------------	-----	--------------------------	---------------------	--------------------------	----------------	--------------------------	--------------------

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
--------------------------	----	--------------------------	-----	--------------------------	---------------------	--------------------------	----------------	--------------------------	--------------------

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
--------------------------	----	--------------------------	-----	--------------------------	---------------------	--------------------------	----------------	--------------------------	--------------------

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
--------------------------	----	--------------------------	-----	--------------------------	---------------------	--------------------------	----------------	--------------------------	--------------------

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
--------------------------	----	--------------------------	-----	--------------------------	---------------------	--------------------------	----------------	--------------------------	--------------------

INSURANCE INFORMATION *PROOF NEEDED*

Covered by health insurance?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:						/			/				
--------------------------	----	--------------------------	-----	-----------------------------	--	--	--	--	--	---	--	--	---	--	--	--	--

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
--------------------------	----	--------------------------	-----	--------------------------	---------------------	--------------------------	----------------	--------------------------	--------------------

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?

<input type="checkbox"/> Medical Report	<input type="checkbox"/> Client Report	<input type="checkbox"/> Other
---	--	--------------------------------

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
--	------------------------------------	---------------------------------------	--	---	------------------------------

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

<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
-----------------------------	------------------------------	--	---	---

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
<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
---	--	--------------------------------

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
-----------------------------	------------------------------	--	---	---