Emergency Shelter Intake Form
(Complete this form for ALL adults)

Client Name: ____________________________________  HMIS Client ID#: ____________________________
(optional)

Project Start Date: ___________________________  ROI Signed?  Yes ____ No ____

For fields in Italics, Check HMIS prior to intake and confirm that the information in HMIS is present and accurate

SS#: ______-____-____  DOB ___/___/______  Veteran?  Yes ____ No _____

Race: (Select as many as client identifies)
_____ American Indian/ Alaska Native or Indigenous  Ethnicity: _____ Hispanic/ Latin(a)(o)(x)
_____ Asian or Asian American  _____ Non-Hispanic/ Latin(a)(o)(x)
_____ Black, African American, or African
_____ Native Hawaiian or Pacific Islander
_____ White

Gender: (Select as many as client identifies)
_____ Female
_____ Male
_____ Transgender (clients who live or identify with a transgender history, experience, or identity)
_____ A gender that is not singularly ‘Female’ or ‘Male’ (e.g., non-binary, genderfluid, agender, culturally specific gender)
_____ Questioning (Unsure, may be exploring, or may not relate to or identify with a gender identity at this time)

Relationship to Head of Household:
_____ Self (Head of Household)
_____ Head of Household’s Child
_____ Head of Household’s Spouse/ Partner
_____ Head of Household’s Other Relation Member
_____ Other: Non-Relation Member

Client Location: _____ NY-505 (Onondaga/ Cayuga/ Oswego counties)
_____ NY-510 (Ithaca/ Tompkins County)

Disabling Condition:
Do you have a DISABILITY of long duration?  ____Yes ____ No
For each disability, check “LCI” if it is expected to be of long, continued and indefinite duration, substantially impairs the individual’s ability to live independently, and is of such a nature that such ability could be improved by more suitable housing conditions.

Disability Type:
_____Yes ___LCI Alcohol Use Disorder  _____Yes ___LCI BOTH Alcohol & Drug Use Disorder  _____Yes ___LCI Drug Use Disorder
_____Yes ___LCI Chronic Health Condition  _____Yes ___LCI Developmental
_____Yes ___LCI Mental Health Disorder  ___________________ HIV/AIDS
_____Yes ___LCI Physical Health
The following questions should be asked and updated for every new entry into shelter:

Medical Insurance:
Do you have Health Insurance/ Medical Assistance?  ____Yes  ____No

Source of Health Insurance/ Medical Assistance:
  ____ Medicaid  ____ Medicare
  ____ State Children’s Health Insurance Program  ____ Veteran’s Administration (VA) Medical Services
  ____ Employer – Provided Health Insurance  ____ Health Insurance obtained through COBRA
  ____ State Health Insurance for Adults  ____ Indian Health Care  ____ Other

Medicaid ID# _________________________________

Medicaid Insurance Company:
  ____ Total Care  ____ Blue Cross Blue Shield  ____ Fidelis
  ____ United Healthcare  ____ Molina Healthcare

Residence Prior to Project Entry (Where did you sleep last night?)

Homeless Situation: (If yes to either of these, fill out the Homeless Situation Questions)
  ____ Place not meant for human habitation
  ____ Emergency shelter, including hotel or motel paid for with emergency shelter voucher

Institutional Situation:
  ____ Foster care home/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/detox center

Did you stay less than 90 days?   Yes ____   No_____
If yes, prior to Institutional Stay were you living on the streets or in a shelter?  Yes ____   No_____
(If yes, answer the Homeless Situation Questions)

Transitional and Permanent Housing Situation:
  ____ Hotel or motel paid without emergency voucher  ____ Owned by client, no on-going housing subsidy
  ____ Owned by client, with on-going housing subsidy
  ____ Permanent housing (other than RRH) for formerly homeless persons
  ____ Rental by client, no ongoing housing subsidy  ____ Rental by client, with VASH Subsidy
  ____ Rental by client, with GPD TIP subsidy
  ____ Residential project or halfway house with no homeless criteria
  ____ Staying in family member’s room/apartment/house
  ____ Staying in friend’s room/apartment/house
  ____ Transitional housing for homeless persons (including homeless youth)

Homeless Situation Questions:

Length of Stay in Previous Place:
  ____ One day or less  ____ Two days to one week  ____ More than one week, less than one month
  ____ One to three months  ____ More than three months, less than one year  ____ One year or longer

Approximate Date Homelessness Started:  ____/____/______
homelessness began. The look back time would not be broken by a stay of less than 7 consecutive nights in any permanent or temporary housing situation nor would it be broken by an institutional stay of less than 90 days (i.e., jail, substance abuse or mental health treatment facility, hospital, or other similar facility). Approximations are permitted.

Zip Code of Last Permanent Address: _______

# of times (episodes) on streets or in ES in 3 years: ___1 ___2 ___3 ___4 or more
Including today, count all the different times the client was on the streets, in an emergency shelter in the last 3 years where there are full breaks in between (i.e., breaks that are 90 days or more in an institution or 7 nights or more in permanent or transitional housing).

Total number of months homeless on the street, in ES in the past 3 years: ______ Months
Count the cumulative number of months in which a person was on the streets or in an ES in the last 3 years, including stays in an institution less than 90 days or in permanent or transitional housing less than 7 days. Round the number of months up to the next highest number of full months. The current month, even if a partial month, can be counted as a full month.

Income:
Do you have income? ____Yes ____ No  Total Monthly Income: $__________
Income Source and amount: (Ask about each source individually and please write in the monthly amount below for each source)

$______ Alimony/ Spousal Support  $______ Child Support
$______ Earned Income  $______ General Assistance
$______ Pension or retirement income from another job  $______ Retirement Income from Social Security
$______ Private Disability Insurance  $______ Social Security Income (SSI)
$______ Social Security Disability Income (SSDI)  $______ Unemployment Insurance
$______ Temporary Assist for Needy Families TANF  $______ VA Service-Connected Disability Compensation
$______ VA Non-Service-Connected Disability Pension
$______ Worker’s Compensation

Non-Cash Benefits:
Do you have Non-Cash Benefits? ____Yes ____ No
Source of Non-Cash Benefits:
_______ Supplemental Nutrition Assistance Program (SNAP) (HUD) (Previously known as Food Stamps)
_______ Special supplemental Nutrition Program for (WIC) (HUD)
_______ TANF Child Care Services (HUD)
_______ TANF Transportation Services (HUD)
_______ Other TANF-Funded Services (HUD); If “Other” Specify: ________________________________

Are you a Victim/ Survivor of Domestic Violence? ____Yes ____ No
If yes, when did it last occur: ______ Within the past 3 months  ______ 3 to 6 months  ______ 6 to 12 months
_______ More than 12 months  ______ Refused

Are you currently fleeing? ____Yes ____ No

Reasons for Homelessness (Please answer for each adult in the household)
In the past year (12 months), did you experience any of the following:
1. Doubled up with friends of family for more than 1 week? ____Yes ____ No
2. Lived in a place where an eviction suit was brought against you or the lease holder? ____Yes ____ No
3. Lived in a place that was declared unfit for human habitation by city/town code enforcement?  __Yes__ __No
4. Received public assistance from the county and lost it for any reason?  ____Yes ____ No
5. Went to the emergency room or hospital for mental health reasons?  ____Yes ____ No
6. Had a large medical expense?  ____Yes ____ No
7. Released from state prison or other long-term criminal justice institution?  ____Yes ____ No
8. Had some other involvement with the criminal justice system (including probation/parole)  ____Yes ____ No
9. Had utilities shut off?  ____Yes ____ No

Are you on Parole:  ____Yes ____ No
If yes, Parole Officer:  ______________________________
Phone Number:  ______ - ______ - ________

Are you a convicted sex offender?  ____Yes ____ No
Sex Offender Case Type:  ____ Level 1
 ____ Level 2
 ____ Level 3

Personal Phone Number:  ______ - ______ - ________

Primary Language:
__Arabic  __Armenian  __Bangali  __Cantonese  __Chinese  __English
__French  __French Creole  __German  __Greek  __Gujarati  __Haitian Creole
__Hebrew  __Hindi  __Hmong  __Italian  __Japanese  __Korean
__Mandarin  __Panjabi  __Persian  __Polish  __Portuguese  __Russian
__Spanish  __Tagalog  __Telugu  __Urdu  __Vietnamese  __Yiddish