

HMIS # _____
Staff Name _____
Date Form Completed ____ / ____ / ____

Santa Cruz County HMIS Runaway and Homeless Youth Enrollment

The service provider should complete this form while interviewing a client. *A separate Enrollment Form is completed for each member of the household, including children.*

1) Client Name	First	Last																				
2) Date of Program Enrollment <i>The date the client started being helped by the project (program); also called the project start date.</i>	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px;"> </td> <td style="width: 25px;"> </td> <td style="width: 25px;">/</td> <td style="width: 25px;"> </td> <td style="width: 25px;"> </td> <td style="width: 25px;">/</td> <td style="width: 25px;"> </td> <td style="width: 25px;"> </td> <td style="width: 25px;"> </td> <td style="width: 25px;"> </td> </tr> <tr> <td>Month</td> <td>Day</td> <td></td> <td>Year</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>				/			/					Month	Day		Year						
		/			/																	
Month	Day		Year																			
3) Housing Move-In Date: <i>(Required for Permanent Housing Projects)</i> <i>This is the date a client moves into a permanent housing situation while enrolled in Rapid Rehousing, Permanent Supportive Housing or Other Permanent Housing programs, even if the move-in date is the same as the project enrollment date.</i>	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px;"> </td> <td style="width: 25px;"> </td> <td style="width: 25px;">/</td> <td style="width: 25px;"> </td> <td style="width: 25px;"> </td> <td style="width: 25px;">/</td> <td style="width: 25px;"> </td> <td style="width: 25px;"> </td> <td style="width: 25px;"> </td> <td style="width: 25px;"> </td> </tr> <tr> <td>Month</td> <td>Day</td> <td></td> <td>Year</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>				/			/					Month	Day		Year						
		/			/																	
Month	Day		Year																			
4) Date of Engagement <i>(only for Street Outreach or Night-by-Night Emergency Shelter)</i> <i>The date the client relationship results in a collaboratively developed action plan with a provider.</i>	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px;"> </td> <td style="width: 25px;"> </td> <td style="width: 25px;">/</td> <td style="width: 25px;"> </td> <td style="width: 25px;"> </td> <td style="width: 25px;">/</td> <td style="width: 25px;"> </td> <td style="width: 25px;"> </td> <td style="width: 25px;"> </td> <td style="width: 25px;"> </td> </tr> <tr> <td>Month</td> <td>Day</td> <td></td> <td>Year</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>				/			/					Month	Day		Year						
		/			/																	
Month	Day		Year																			

Client Name _____

Head of Household Name (if not Self) _____

<p>5) Prior Living Situation <i>What was the client's living situation the night before enrolling in the project?</i></p> <p><i>Ask the client "where did you stay or sleep last night"?</i></p>	<p><u>Homeless Situations</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Place not meant for human habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport/or anywhere outside) <input type="checkbox"/> Emergency Shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter <input type="checkbox"/> Safe Haven <p><u>Institutional Situations</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non—psychiatric medical facility <input type="checkbox"/> Jail, prison or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center <p><u>Transitional & Permanent Housing Situations</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Hotel or motel Paid for without emergency shelter voucher <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Staying or living in a friend's room, apartment or house <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> Rental by client with GPD TIP housing subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons <input type="checkbox"/> Rental by client, with RRH or equivalent subsidy <input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based) <input type="checkbox"/> Rental by client in a public housing unit <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy <p><u>Other</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
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<p>6) Length of stay in prior living situation <i>How long have you been sleeping/staying where you stayed/slept last night? If the client has stayed in similar situations (e.g., outside, homes of friends) but not exactly the same PLACE, include the total time in that type of situation.</i></p>	<ul style="list-style-type: none"> <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 <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
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Client Name _____

Head of Household Name (if not Self) _____

<p>7) If the client stayed in an Institutional Situation last night, was the stay less than 90 days?</p> <p>If the response is “Yes”, did the client stay on the streets or in emergency shelter the night before going to the institutional situation?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>														
<p>8) If the client stayed in Transitional/Permanent housing last night, was the stay less than 7 days?</p> <p>If the response is “Yes”, did the client stay on the streets or in emergency shelter the night before going to the transitional or permanent placement?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>														
<p>9) Approximate date <u>this</u> current homeless situation began:</p> <p><i>When was the date the current homeless situation began?</i></p> <p><i>A break in homelessness is defined as being off the street or out of shelter for 7 days or more or spending 90 days or more in an institution.</i></p>	<p><input type="checkbox"/> Not Applicable</p> <table border="1" data-bbox="589 976 1015 1041"> <tr> <td></td><td></td><td></td><td>/</td><td></td><td></td><td></td><td>/</td><td></td><td></td><td></td><td></td><td></td> </tr> </table> <p>This information can be by client self-report</p>					/				/					
			/				/								
<p>10) Number of times the client has been on the streets or in Emergency Shelter in the <u>past three years</u> including today</p>	<p><input type="checkbox"/> One Time <input type="checkbox"/> Two Times <input type="checkbox"/> Three Times</p>	<p><input type="checkbox"/> Four or more times <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused</p>													
<p>11) Total number of months client has been on the streets or in Emergency Shelter in the <u>past three years</u></p>	<p><input type="checkbox"/> One month (this time is the first month) <input type="checkbox"/> 2 months <input type="checkbox"/> 7 months <input type="checkbox"/> 3 months <input type="checkbox"/> 8 months <input type="checkbox"/> 4 months <input type="checkbox"/> 9 months <input type="checkbox"/> 5 months <input type="checkbox"/> 10 months <input type="checkbox"/> 6 months <input type="checkbox"/> 11 months</p> <p><input type="checkbox"/> 12 months <input type="checkbox"/> More than 12 months <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused</p>														

Client Name _____

Head of Household Name (if not Self) _____

Disabling Conditions (All Responses required)

<p>1) Does the client currently have a disabling condition? <i>A Disabling Condition is a health condition that interferes with getting and/or keeping stable housing.</i></p> <p><i>This question is used with other information to determine if the client meets criteria for chronic homelessness.</i></p> <p>All questions in this section MUST be answered even if the answer is “no” to this question.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused	
<p>2) Does the client have a Physical Disability?</p> <p><i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused	
<p>3) Does the client have a Developmental Disability?</p> <p><i>If Yes, is it expected to substantially impair the client's ability to live independently?</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused	
<p>4) Does the client have a Chronic Health Condition?</p> <p><i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
<p>5) Does the client have HIV – AIDS?</p> <p><i>If Yes, is it expected to substantially impair the client's ability to live independently?</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused	

Client Name _____

Head of Household Name (if not Self) _____

<p>6) Does the client have a Mental Health Disorder?</p> <p><i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
<p>7) Does the client have any Substance Use Disorder?</p> <p><i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i></p>	<input type="checkbox"/> No <input type="checkbox"/> Alcohol use disorder <input type="checkbox"/> Drug use disorder <input type="checkbox"/> Both Alcohol & Drug Abuse Use Disorders	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Domestic Violence

<p>1) Domestic Violence Victim/Survivor</p> <p><i>Ask the client "Have you ever experienced any domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions against you or a member of your family, including a child, that has happened in the place you were living?"</i></p> <p><i>If the answer is "no", skip to "Monthly Income – Cash Benefits" section.</i></p> <p><i>If the answer is "yes", COMPLETE questions 2 and 3.</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>2) Most Recent Occurrence</p> <p><i>Ask the client "How long ago was your most recent experience of domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions?"</i></p>	<input type="checkbox"/> Within the past three months <input type="checkbox"/> Three to six months ago (excluding six months exactly) <input type="checkbox"/> Six months to one year ago (excluding one year exactly) <input type="checkbox"/> One year ago or more <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
<p>3) Current Status</p> <p><i>Ask the client "Are you currently fleeing, or attempting to flee, the domestic violence situation, or are you afraid to return to the place you are living?"</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Client Name _____

Head of Household Name (if not Self) _____

Monthly Income – Cash Benefits

<p>Current income from any source? <i>Is the client currently receiving any income from any source?</i></p> <p>Specify the type(s) and amount(s) of income the client currently receives. <i>Only regular, recurrent sources that are current today should be included. Income received for a minor (under 18 years old) member of the household (e.g., SSI) should be recorded with the HoH's information.</i></p> <p><i>DO NOT include income received by other adults (18 years and older) in the household; record their income on their Enrollment form.</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused</p> <hr/> <p><input type="checkbox"/> Earned Income \$ _____</p> <p><input type="checkbox"/> Unemployment Insurance \$ _____</p> <p><input type="checkbox"/> Supplemental Security Income SSI \$ _____</p> <p><input type="checkbox"/> Social Security Disability Insurance SSDI \$ _____</p> <p><input type="checkbox"/> VA Service-Connected Disability Pension \$ _____</p> <p><input type="checkbox"/> VA Non-service connect disability pension \$ _____</p> <p><input type="checkbox"/> Private Disability Insurance \$ _____</p> <p><input type="checkbox"/> Worker's Compensation \$ _____</p> <p><input type="checkbox"/> Temporary Assistance for Needy Families TANF/CalWORKs \$ _____</p> <p><input type="checkbox"/> General Assistance (GA) \$ _____</p> <p><input type="checkbox"/> Retirement income from Social Security \$ _____</p> <p><input type="checkbox"/> Pension or Retirement Income from a Former Job \$ _____</p> <p><input type="checkbox"/> Child Support \$ _____</p> <p><input type="checkbox"/> Alimony and Other Spousal Support \$ _____</p> <p><input type="checkbox"/> Other Cash Income \$ _____</p> <p>If Other Specify: _____</p>
<p>Total Cash Income for Individual</p>	<p>TOTAL: \$ _____</p>

Client Name _____

Head of Household Name (if not Self) _____

Non-Cash Benefits

<p>Currently receiving Non-Cash Benefits? <i>Is the client currently receiving one of the non-cash benefits listed below?</i></p> <p>If Yes, indicate all the non-cash benefits the client is receiving:</p> <p><i>Only regular, recurrent sources that are current today should be included. Record non-cash benefits received by a minor member (under 18 years of age) of the household under the HoH's information.</i></p> <p><i>DO NOT include benefits received by other adults (18 years and older) in the household; record their benefits on their Enrollment form.</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
	<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP)/Cal Fresh <input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) <input type="checkbox"/> TANF/CALWORKS Childcare Services <input type="checkbox"/> TANF/CALWORKS Transportation Services <input type="checkbox"/> Other TANF/CALWORKS-Funded Services <input type="checkbox"/> Other Non-Cash Benefit If Other Specify: _____

Health Insurance

<p>Currently covered by health insurance? <i>Is the client currently covered by health insurance?</i></p> <p>If Yes, type(s) of insurance(s):</p> <p><i>If the client is currently covered by multiple health insurances please select all that apply.</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
	<input type="checkbox"/> Medicaid (same as Medi-Cal) <input type="checkbox"/> Medicare <input type="checkbox"/> State Children's Health Insurance (CHIP) Program <input type="checkbox"/> Veteran's Administration (VA) Medical Services <input type="checkbox"/> Employer-Provided Health Insurance <input type="checkbox"/> Health Insurance Obtained Through COBRA <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Other Health Insurance If Other Specify: _____

Client Name _____

Head of Household Name (if not Self) _____

Sexual Orientation

What is the client's sexual orientation?	<input type="checkbox"/> Heterosexual <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Other (please specify) _____	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
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Education Status

Specify the last grade of school completed by the client	<input type="checkbox"/> Less than Grade 5 <input type="checkbox"/> Grades 5-6 <input type="checkbox"/> Grades 7-8 <input type="checkbox"/> Grades 9-11 <input type="checkbox"/> Grade 12/ High school diploma <input type="checkbox"/> School program does not have grade levels	<input type="checkbox"/> GED <input type="checkbox"/> Some college <input type="checkbox"/> Associate's degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Graduate degree <input type="checkbox"/> Vocational certification <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
RHY School Status	<input type="checkbox"/> Attending School Regularly <input type="checkbox"/> Attending School Irregularly <input type="checkbox"/> Graduate from High School <input type="checkbox"/> Obtained GED <input type="checkbox"/> Dropped Out	<input type="checkbox"/> Suspended <input type="checkbox"/> Expelled <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Employment Status

Currently Employed? <i>Is the client currently employed?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
If Yes, specify the type of employment	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Seasonal/Sporadic (including day labor)	
If No, is the client looking for employment?	<input type="checkbox"/> Looking for work <input type="checkbox"/> Unable to work <input type="checkbox"/> Not looking for work	

Client Name _____

Head of Household Name (if not Self) _____

Health Status

<p>1) Clients' general health status.</p>	<p><input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor</p> <p><input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>																				
<p>2) Client's dental health status.</p>	<p><input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor</p> <p><input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>																				
<p>3) Client's mental health status.</p>	<p><input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor</p> <p><input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>																				
<p>4) Client's pregnancy status.</p> <p>If yes, due date:</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p> <table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;">/</td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;">/</td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> </tr> <tr> <td colspan="3">Month</td> <td colspan="3">Day</td> <td colspan="4">Year</td> </tr> </table>			/			/					Month			Day			Year			
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Month			Day			Year															

Other System Involvement

<p>1) Youth was formerly a ward of Child Welfare or a Foster Care Agency.</p> <p>If yes, how long were they a ward of child welfare of a foster care agency?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p> <p><input type="checkbox"/> 3 to 5 years or more <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> Less than one year: specify number of months _____</p>
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Client Name _____

Head of Household Name (if not Self) _____

2) Youth was formerly a ward of the Juvenile Justice System. If yes, how long were they a ward of the Juvenile Justice System?	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know
	<input type="checkbox"/> No	<input type="checkbox"/> Client Refused
<input type="checkbox"/> 3 to 5 years or more <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> Less than one year: specify number of months _____		

Family Critical Issues [Adults and Head of Households, All program types except Street Outreach]

1) Unemployment – Family Member	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
2) Mental Health Disorder – Family Member	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
3) Physical Disability – Family Member	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
4) Alcohol or Substance Use Disorder – Family Member	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
5) Insufficient income to support youth – Family Member	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
6) Incarcerated parent of youth	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Referral Source

<input type="checkbox"/> Self -referral <input type="checkbox"/> Individual: Parent/Guardian/Relative/Friend/Foster <input type="checkbox"/> Parent/Other Individual <input type="checkbox"/> Outreach <input type="checkbox"/> Temporary Shelter <input type="checkbox"/> Residential Project <input type="checkbox"/> Hotline <input type="checkbox"/> Child Welfare/CPS <input type="checkbox"/> Juvenile Justice	<input type="checkbox"/> Law Enforcement/Police <input type="checkbox"/> Mental Hospital <input type="checkbox"/> School <input type="checkbox"/> Other organization <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
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Client Name _____

Head of Household Name (if not Self) _____

Last Permanent Address

<p>This is the address of the client's last <u>permanent housing prior to this experience of homelessness</u>: not the address of a shelter or a location not meant for human habitation like the streets or a park.</p>	Street Address	City
	State	Zip Code

Client Name _____

Head of Household Name (if not Self) _____