Alameda County HMIS

CLARITY HMIS: COORDINATED ENTRY ENROLLMENT FORM – WITH ADDRESS

Use block letters for text and bubbles in the appropriate circles.
Please complete a separate form for each household member.

CLIENT NAME OR IDENTIFIER: _____

PROJECT START DATE *[All Clients]*

		/			/				
Month			**Day**			**Year**			

IF "YES" TO TRANSLATION ASSISTANCE NEEDED – INDICATE PREFERRED LANGUAGE

○	Albanian	○	Hebrew	○	Punjabi
○	American Sign Language	○	Hindi	○	Romanian
○	Amharic	○	Hmong	○	Russian
○	Arabic	○	Hungarian	○	Serbian
○	Armenian	○	Igbo	○	Sinhalese
○	Bengali	○	Indonesian	○	Slovak
○	Bosnian	○	Italian	○	Somali
○	Bulgarian	○	Japanese	○	Spanish
○	Burmese	○	Khmer	○	Swedish
○	Chinese	○	Korean	○	Tagalog
○	Croatian	○	Laotian	○	Tamil
○	Czech	○	Lithuanian	○	Telugu
○	Dutch	○	Malayalam	○	Thai
○	English	○	Mam	○	Turkish
○	Farsi	○	Marathi	○	Ukrainian
○	French	○	Navajo	○	Urdu
○	German	○	Nepali	○	Vietnamese
○	Greek	○	Polish	○	Yiddish
○	Haitian Creole	○	Portuguese	○	Yoruba
○	Different Preferred Language (*specify*):	○	Client doesn't know		
		○	Client prefers not to answer		
		○	Data not collected		

ENROLLMENT CoC *[only if multiple CoC's]* _____

WHEN CLIENT WAS ENGAGED *[Street Outreach Only or Night by Night Emergency Shelter]*

Date of Engagement:	____/____/_____

IN PERMANENT HOUSING *[Permanent Housing Projects, for Head of Household]*

○	No	○	Yes
IF "YES" TO PERMANENT HOUSING			
Housing Move-In Date:	____/____/_____		

PRIOR LIVING SITUATION

TYPE OF RESIDENCE *[Head of Household and Adults]*

○	Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport, or anywhere outside)	○	Hotel or motel paid for without emergency shelter voucher
○	Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or Host Home shelter	○	Host Home (non-crisis)
○	Safe Haven	○	Staying or living in a friend's room, apartment, or house
○	Foster care home or foster care group home	○	Staying or living in a family member's room, apartment or house
○	Hospital or other residential non-psychiatric medical facility	○	Rental by client, no ongoing housing subsidy
○	Jail, prison or juvenile detention facility	○	Rental by client, with ongoing housing subsidy
○	Long-term care facility or nursing home	○	Owned by client, with on-going housing subsidy
○	Psychiatric hospital or other psychiatric facility	○	Owned by client, no on-going housing subsidy
○	Substance abuse treatment facility or detox center	○	Client doesn't know
○	Transitional housing for homeless persons (including homeless youth)	○	Client prefers not to answer
○	Residential project or halfway house with no homeless criteria	○	Data not collected
IF "RENTAL BY CLIENT, WITH ONGOING HOUSING SUBSIDY" – SPECIFY:			
○	GPD TIP housing subsidy	○	Emergency Housing Voucher
○	VASH Housing subsidy	○	Family Unification Program Voucher (FUP)
○	RRH or equivalent subsidy	○	Foster Youth to Independence Initiative (FYI)
○	HCV voucher (tenant or project based) (not dedicated)	○	Permanent Supportive Housing
○	Public Housing Unit	○	Other permanent housing dedicated for formerly homeless persons
○	Rental by client, with other ongoing housing subsidy		

LENGTH OF STAY IN PRIOR LIVING SITUATION

○	One night or less	○	One month or more, but less than 90 days	○	Client doesn't know
○	Two to six nights	○	90 days or more, but less than one year	○	Client prefers not to answer

○	One week or more, but less than one month	○	One year or longer	○	Data not collected

LENGTH OF STAY LESS THAN 7 NIGHTS *[TH, PH]*

○	No	○	Yes

LENGTH OF STAY LESS THAN 90 DAYS [*Institutional Housing Situations]*

○	No	○	Yes

ON THE NIGHT BEFORE – STAYED ON THE STREETS, EMERGENCY SHELTER, SAFE HAVEN *[Head of Household and Adults]*

○	Yes	○	No
Approximate Date This Episode of Homelessness Started		____/____/_____	
Number of *times* the client has been on the streets, ES, or Safe Haven in the last 3 years			
○	One Time	○	Client doesn't know
○	Two Times	○	Client prefers not to answer
○	Three Times	○	Data not collected
○	Four or More Times		
Total number of *months* homeless on the streets, ES, or Safe Haven in the last 3 years			
○	One month (this time is the first month)	○	Client doesn't know
○	2-12 months (specify number of months): _____	○	Client prefers not to answer
○	More than 12 months	○	Data not collected

LENGTH OF STAY IN PRIOR LIVING SITUATION

○	One night or less	○	One month or more, but less than 90 days	○	Client doesn't know
○	Two to six nights	○	90 days or more, but less than one year	○	Client prefers not to answer

RESOURCE ZONE *[All Clients]*

○	East County (Dublin, Pleasanton, Livermore)	○	Mid County East (Hayward, Unincorporated)
○	Mid County West (Alameda, San Leandro)	○	North County (Berkeley, Emeryville, Albany)
○	Oakland	○	South County (Fremont, Newark, Union City)

HCS REFERRAL SOURCE *[All Clients]*

○	Street Health	○	Access Point
○	Other		

HCS REFERRAL SOURCE - OTHER *[All Clients]*

○	

WHAT WAS THE ADDRESS OF THE LAST PLACE YOU LIVED OR STAYED FOR MORE THAN 30 DAYS THAT WAS EITHER YOUR OWN PLACE OR SOMEONE ELSE'S HOME?
(DOES NOT INCLUDE STAYS IN SHELTER, TREATMENT PROGRAMS, OR OTHER TEMPORARY PLACES LIKE HOSPITALS OR JAILS.)

Prior Street Address				
Prior City				
Prior State		Zip Code of Last Address		
Prior Address Data Quality	○ Full Address reported		○	Incomplete or estimated Address reported
	○ Client doesn't know		○	Client prefers not to answer
	○ Data not collected			

DISABLING CONDITION *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected

PHYSICAL DISABILITY *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected
IF "YES" TO PHYSICAL DISABILITY – SPECIFY			
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	○ No	○	Client doesn't know
	○ Yes	○	Client prefers not to answer
		○	Data not collected

DEVELOPMENTAL DISABILITY *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected

CHRONIC HEALTH CONDITION *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected
IF "YES" TO CHRONIC HEALTH CONDITION – SPECIFY			
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	○ No	○	Client doesn't know
	○ Yes	○	Client prefers not to answer
		○	Data not collected

HIV-AIDS *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected

MENTAL HEALTH DISORDER *[All Clients]*

○	No	○	Client doesn't know

○	Yes	○	Client prefers not to answer
		○	Data not collected
IF "YES" TO MENTAL HEALTH DISORDER – SPECIFY			
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	○ No ○ Yes	○	Client doesn't know Client prefers not to answer Data not collected

SUBSTANCE USE DISORDER *[All Clients]*

○	No	○	Client doesn't know
○	Alcohol use disorder	○	Client prefers not to answer
○	Drug use disorder	○	Data not collected
○	Both alcohol and drug use disorders		
IF "ALCOHOL USE DISORDER" "DRUG USE DISORDER" OR "BOTH ALCOHOL AND DRUG USE DISORDERS" – SPECIFY			
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	○ No ○ Yes	○	Client doesn't know Client prefers not to answer Data not collected

SURVIVOR OF DOMESTIC VIOLENCE *[Head of Household and Adults]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected
IF "YES" TO SURVIVOR OF DOMESTIC VIOLENCE – SPECIFY WHEN EXPERIENCE OCCURRED			
○	Within the past three months	○	Client doesn't know
○	Three to six months ago (excluding six months exactly)	○	Client prefers not to answer
○	Six months to one year ago (excluding one year exactly)	○	Data not collected
○	One year ago or more		
Are you currently fleeing?	○ No ○ Yes	○	Client doesn't know Client prefers not to answer Data not collected

INCOME FROM ANY SOURCE *[Head of Household and Adults]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected

IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY

	Income Source	**Amount**		**Income Source**	**Amount**
○	Earned Income		○	Temporary Assistance for Needy Families (TANF)	
○	Unemployment Insurance		○	General Assistance (GA)	
○	Supplemental Security Income (SSI)		○	Retirement income from Social Security	
○	Social Security Disability Insurance (SSDI)		○	Pension or retirement income from a former job	
○	VA Service-Connected Disability Compensation		○	Child support	
○	VA Non-Service-Connected Disability Pension		○	Alimony and other spousal support	
○	Private disability insurance		○	Other income source *(specify):*	
○	Worker's Compensation				
Total Monthly Income for Individual:					

RECEIVING NON-CASH BENEFITS *[Head of Household and Adults]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected
IF "YES" TO NON-CASH BENEFITS – INDICATE ALL SOURCES THAT APPLY			
○	Supplemental Nutrition Assistance Program (SNAP)	○	TANF Child Care Services
○	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	○	TANF Transportation Services
○	Other (specify):	○	Other TANF-funded services

COVERED BY HEALTH INSURANCE *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected
IF "YES" TO HEALTH INSURANCE – HEALTH INSURANCE COVERAGE DETAILS			
○	MEDICAID	○	Employer Provided Health Insurance
○	MEDICARE	○	Health Insurance Obtained Through COBRA
○	State Children's Health Insurance (SCHIP)	○	Private Pay Health Insurance
○	Veteran's Health Administration (VHA)	○	State Health Insurance for Adults
○	Other (specify):	○	Indian Health Services Program

SEXUAL ORIENTATION *[For CoC: YHDP and PSH funded programs – Adults and Head of Household]*

○	Heterosexual	○	Other
○	Gay	*If Other please specify:*	
○	Lesbian	○	Client doesn't know
○	Bisexual	○	Client prefers not to answer
○	Questioning/Unsure	○	Data not collected

_____

Signature of applicant stating all information is true and correct **Date**