A Tradition of Stewardship
A Commitment to Service

Napa County Continuum of Care

HMIS Adult Client Enrollment
Abode Services Agency – HDAP Program

ABODE Services

Program Name: _____ Case Worker/Intake Person: _____ Program Start Date: _____

CLIENT ENROLLMENT

Separate client enrollments should be completed for each client who is **over** the age of 17 or the Head of Household. **Separate client enrollments must be completed for children as well, but please be sure to use the Standard HMIS Child Client Enrollment form.**

1) Client Name	**First**	**Last**
Relationship to Head of Household	❑ Self (Head of Household) ❑ Head of Household's child ❑ Head of Household's spouse or partner ❑ Head of Household's other relation member (other relation to Head of Household) ❑ Other: non-relation member	
2) Date of Program Enrollment *The date the client started being helped by the project (program); also called the project start date.*	/ / Month Day Year	
3) Translation Assistance Needed *[Head of Household only]* *Does the client need access to translation services?*	❑ No ❑ Yes ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected	
If Yes, Preferred Language(s): *If the client needs access to translation services, please select their preferred language(s).*	❑ American Sign Language ❑ Arabic ❑ Armenian ❑ Black American Sign Lanugage ❑ Cantonese ❑ Cape Verdean Creole ❑ Chinese ❑ English ❑ Farsi	❑ Mixteco ❑ Persian ❑ Portuguese ❑ Punjabi ❑ Russian ❑ Spanish ❑ Tagalog ❑ Taiwanese ❑ Thai

Client Name_____

Head of Household Name (if not Self) _____

	❑ Fijian ❑ Filipino ❑ French ❑ Greek ❑ Haitian ❑ Hindi ❑ Hmong ❑ Korean ❑ Mandarin	❑ Ukrainian ❑ Vietnamese ❑ Different Preferred Language, please specify: _____ ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected
PRIOR LIVING SITUATION – *ANSWER ONLY ONE FULL SECTION*: *A* or *B* or *C* [Head of Household and Adults only]		
Type of Residence *A – Homeless Living Situations* *What was the client's living situation the night before enrolling in the project?* *Ask the client "where did you stay or sleep last night"?*	❑ Place not meant for human habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport/or anywhere outside) ❑ Emergency Shelter, including hotel or motel paid for with emergency shelter voucher, or Host Home shelter ❑ Safe Haven	
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 prefers not to answer ❑ Data Not Collected
Approximate date *this episode* of homelessness started: *When was the date the current homeless situation began?* *A break in homelessness is defined as being in any permanent or temporary housing situation for 7 consecutive nights or more, or spending 90 days or more in an institution (i.e., jail, substance abuse or mental health treatment facility, hospital, or other similar facility).*	__ __ / __ __ / __ __ __ __	
Number of *times* the client has been on the streets or in Emergency Shelter in the last three years	❑ One Time ❑ Two Times ❑ Three Times	❑ Four or more times ❑ Client doesn't know ❑ Client prefers not to answer

Client Name_____

Head of Household Name (if not Self) _____

		❑ Data Not Collected
Total number of *months* client has been homeless on the streets or in Emergency Shelter in the <u>last three years</u>	❑ One month (this time is the first month) ❑ 2 months ❑ 7 months ❑ 3 months ❑ 8 months ❑ 4 months ❑ 9 months ❑ 5 months ❑ 10 months ❑ 6 months ❑ 11 months	❑ 12 months ❑ More than 12 months ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected
Type of Residence *<u>B – Institutional Living Situations</u>* *What was the client's living situation the night before enrolling in the project?* *Ask the client "where did you stay or sleep last night"?*	❑ Foster care home or 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 or detox center	
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 prefers not to answer ❑ Data Not Collected
Was the length of stay less than 90 days? *If the response is "No," STOP here and skip down to the Disability section.*	❑ Yes ❑ No	
If the response is "Yes", did the client stay on the streets or in emergency shelter the night before going to the institutional situation? *If the response is "No," STOP here and skip down to the Disability section.* *If the response is "Yes," please answer the following questions below:*	❑ Yes ❑ No	
Approximate date *<u>this episode</u>* of homelessness started: *When was the date the current homeless situation began?* *A break in homelessness is defined as being in any permanent or temporary housing situation for 7 consecutive nights or more, or spending 90 days or more in an institution (i.e., jail,*	☐☐/☐☐/☐☐☐☐	

Client Name_____

Head of Household Name (if not Self) _____

substance abuse or mental health treatment facility, hospital, or other similar facility).		
Number of *times* the client has been on the streets or in Emergency Shelter in the last three years	❑ One Time ❑ Two Times ❑ Three Times	❑ Four or more times ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected
Total number of *months* client has been homeless on the streets or in Emergency Shelter in the last three years	❑ One month (this time is the first month) ❑ 2 months ❑ 7 months ❑ 3 months ❑ 8 months ❑ 4 months ❑ 9 months ❑ 5 months ❑ 10 months ❑ 6 months ❑ 11 months	❑ 12 months ❑ More than 12 months ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected
Type of Residence *C – Transitional OR Permanent Housing Living Situations* *What was the client's living situation the night before enrolling in the project?* *Ask the client "where did you stay or sleep last night"?*	**Temporary Housing Situations** ❑ Transitional housing for homeless persons (including homeless youth) ❑ Residential project or halfway house with no homeless criteria ❑ Hotel or motel paid for without emergency shelter voucher ❑ Host Home (non-crisis) ❑ Staying or living in a friend's room, apartment, or house ❑ Staying or living in a family member's room, apartment, or house **Permanent Housing Situations** ❑ Rental by client, no ongoing housing subsidy ❑ **Rental by client, with ongoing housing subsidy** ❑ Owned by client, with ongoing housing subsidy ❑ Owned by client, no ongoing housing subsidy	**Other** ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected
Rental Subsidy Type: *If **"Rental by client, with ongoing housing subsidy"** is selected, please select the type of housing subsidy in use.*	❑ GPD TIP housing subsidy ❑ VASH housing subsidy ❑ RRH or equivalent subsidy ❑ HCV voucher (tenant or project based) (not dedicated) ❑ Public housing unit ❑ Rental by client, with other ongoing housing subsidy ❑ Emergency Housing Voucher (EHV) ❑ Family Unification Program Voucher (FUP) ❑ Foster Youth to Independence Initiative (FYI) ❑ Permanent Supportive Housing ❑ Other permanent housing dedicated for formerly homeless persons	

Client Name_____

Head of Household Name (if not Self) _____

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 prefers not to answer ❑ Data Not Collected
Was the length of stay less than 7 nights? *If the response is "No," STOP here and skip down to the Disability section.*	❑ Yes ❑ No	
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? *If the response is "No," STOP here and skip down to the Disability section.* *If the response is "Yes," please answer the following questions below:*	❑ Yes ❑ No	
Approximate date *<u>this episode</u>* of homelessness started: *When was the date the current homeless situation began?* *A break in homelessness is defined as being in any permanent or temporary housing situation for 7 consecutive nights or more, or spending 90 days or more in an institution (i.e., jail, substance abuse or mental health treatment facility, hospital, or other similar facility).*	| | | / | | | / | | | |	
Number of *times* the client has been on the streets or in Emergency Shelter in the <u>last three years</u>	❑ One Time ❑ Two Times ❑ Three Times	❑ Four or more times ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected
Total number of *months* client has been homeless on the streets or in Emergency Shelter in the <u>last three years</u>	❑ One month (this time is the first month) ❑ 2 months ❑ 7 months ❑ 3 months ❑ 8 months ❑ 4 months ❑ 9 months	❑ 12 months ❑ More than 12 months ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected

Client Name_____

Head of Household Name (if not Self) _____

	❑ 5 months ❑ 10 months ❑ 6 months ❑ 11 months	
DISABLING CONDITIONS: A Disabling Condition is a health condition that interferes with getting and/or keeping stable housing.		
1) Does the client currently have a disabling condition? *A Disabling Condition is a health condition that interferes with getting and/or keeping stable housing.* *This question is used with other information to determine if the client meets criteria for chronic homelessness.* ***All questions in this section MUST be answered even if the answer is "no" to this question.***	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected
2) Does the client have a Physical Disability?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected
If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected
3) Does the client have a Developmental Disability?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected
4) Does the client have a Chronic Health Condition?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected
If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected
5) Does the client have HIV – AIDS?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected
6) Does the client have a Mental Health Disorder?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected

Client Name_____

Head of Household Name (if not Self) _____

If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected
7) Does the client have any Substance Use Disorder?	❑ No ❑ Alcohol use disorder ❑ Drug use disorder ❑ Both Alcohol & Drug Abuse Use Disorders	❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected
If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected

DOMESTIC VIOLENCE [Head of Household and Adults only]

1) Survivor of Domestic Violence *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?"* ***If the answer is "no", skip to "Monthly Income – Cash Benefits" section.*** ***If the answer is "yes", COMPLETE questions 2 and 3.***	❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected
2) Most Recent Occurrence *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?"*	❑ Within the past three months ❑ Three to six months ago (excluding six months exactly) ❑ Six months to one year ago (excluding one year exactly) ❑ One year ago or more ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected
3) Current Status *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?"*	❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected

MONTHLY INCOME – CASH BENEFITS [Head of Household and Adults only]

Current income from any source?	❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected

Client Name_____

Head of Household Name (if not Self) _____

Is the client currently receiving any income from any source?	
Specify the type(s) and amount(s) of income the client currently receives. *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.* *DO NOT include income received by other adults (18 years and older) in the household; record their income on their Enrollment form.*	❑ Earned Income $_____ ❑ Unemployment Insurance $_____ ❑ Supplemental Security Income SSI $_____ ❑ Social Security Disability Insurance SSDI $_____ ❑ VA Service-Connected Disability Pension$_____ ❑ VA Non-service connect disability pension $_____ ❑ Private Disability Insurance $_____ ❑ Worker's Compensation $_____ ❑ Temporary Assistance for Needy Families TANF/CalWORKs $_____ ❑ General Assistance (GA) $_____ ❑ Retirement income from Social Security $_____ ❑ Pension or Retirement Income from a Former Job $_____ ❑ Child Support $_____ ❑ Alimony and Other Spousal Support $_____ ❑ Other Cash Income $_____ If Other Specify: _____
Total Monthly Cash Income for Individual	**TOTAL: $** $ 0.00

NON-CASH BENEFITS [Head of Household and Adults only]	
Currently receiving Non-Cash Benefits? *Is the client currently receiving one of the non-cash benefits listed below?*	❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected
If Yes, indicate all the non-cash benefits the client is receiving: *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.* *DO NOT include benefits received by other adults (18 years and older) in the household; record their benefits on their Enrollment form.*	❑ Supplemental Nutrition Assistance Program (SNAP)/Cal Fresh ❑ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) ❑ TANF/CALWORKS Childcare Services ❑ TANF/CALWORKS Transportation Services ❑ Other TANF/CALWORKS-Funded Services ❑ Other Non-Cash Benefit If Other Specify: _____

Client Name_____

Head of Household Name (if not Self) _____

HEALTH INSURANCE	
Currently covered by health insurance? *Is the client currently covered by health insurance?*	❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected
If Yes, type(s) of insurance(s): *If the client is currently covered by multiple health insurances please select all that apply.*	❑ Medicaid (same as Medi-Cal) ❑ Medicare ❑ State Children's Health Insurance (CHIP) Program ❑ Veteran's Health Administration (VHA) ❑ Employer-Provided Health Insurance ❑ Health Insurance Obtained Through COBRA ❑ Private Pay Health Insurance ❑ State Health Insurance for Adults ❑ Indian Health Services Program ❑ Other Health Insurance If Other Specify: _____
HDAP Required Questions [Head of Household and Adults only]	
At approval, sex	❑ Female ❑ Male ❑ Transgender: Male to Female ❑ Transgender: Female to Male ❑ Nonbinary (neither Male nor Female)
At approval, gender identity	❑ Female ❑ Male ❑ Transgender: Male to Female ❑ Transgender: Female to Male ❑ Nonbinary (neither Male nor Female) ❑ Another gender identity ❑ Decline to state
Sexual Orientation	❑ Straight or Heterosexual ❑ Gay or Lesbian ❑ Bisexual ❑ Queer ❑ Another Sexual Orientation ❑ Unknown ❑ Decline to state

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At approval, which HDAP target population(s) is the participant a member of? *You may select multiple populations per participant*	❑ General Assistance/General Relief ❑ CalWORKs ❑ Diverted from Jail/Prison ❑ Low Income Veterans ❑ Discharged from Institution ❑ Low income/No income (none of the above)

Client Name_____

Head of Household Name (if not Self) _____