HMIS # _____

Staff Name _____

Date Form Completed _____/_____/_____

Santa Cruz County HMIS – HOPWA Adult Enrollment

The service provider should complete this form while enrolling an adult client or the Head of Household into a HOPWA-funded program. 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 HOPWA Child Enrollment form.**

1) Client Name	**First** **Last**
Relationship to HoH (HUD) *Single individuals are also heads of household (HoH). In multiple person households one person must be designated head of household*	❑ Self (HoH) ❑ Child of HoH ❑ Spouse/partner of HoH ❑ Relative member of household ❑ Non-relative member of household
Relationship to HoH – Additional Detail	❑ Self ❑ Husband/Wife ❑ Son/Daughter ❑ Father/Mother ❑ Sister/Brother ❑ Roommate ❑ Grandchild ❑ Aunt/Uncle ❑ Niece/Nephew ❑ Grandparent ❑ Significant Other ❑ Domestic Partner ❑ Other ❑ Stepdaughter/Stepson
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

Client Name _____

Head of Household Name (if not Self) _____

3) Translation Assistance Needed

[Head of Household]

Does the client need access to translation services?

❑ No
❑ Yes
❑ Client doesn't know
❑ Client prefers not to answer

If Yes, Preferred Language(s):

If the client needs access to translation services, please select their preferred language(s).

❑ Spanish
❑ Mixteco
❑ Zapoteco
❑ Tzotil
❑ Mandarin
❑ Cantonese
❑ American Sign Language
❑ Farsi
❑ Arabic
❑ Russian
❑ Portuguese
❑ Samoan
❑ Tagalog
❑ Vietnamese
❑ Korean
❑ Cambodian
❑ Different Preferred Language, please specify:

_____

❑ Client doesn't know
❑ Client prefers not to answer

4) Housing Move-In Date

[Head of Household]

(*Required for Permanent Housing Projects*)

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. ***Leave blank if there is no move-in date yet. Update the enrollment data with a move-in date after move-in happens.***

		/			/				

Month Day Year

5) Date of Engagement *(only for Street Outreach, Night-by-Night Emergency Shelter, or Services Only programs)*

[Head of Household and Adults]

The date the client relationship results in a collaboratively developed action plan with a provider. ***Leave blank if still working to engage. Update the enrollment data after engagement happens.***

		/			/				

Month Day Year

Client Name _____

Head of Household Name (if not Self) _____

6) Prior Living Situation: Type of Residence [Head of Household and Adults] ***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"?* ***There are no Safe Havens in Santa Cruz County.*** This could apply if the client spent the night before in a Safe Haven in another County.	**Homeless Situations** ❑ 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 **Institutional Situations (Answer Q8)** ❑ 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 **Temporary Housing Situations (Answer Q9)** ❑ 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 (Answer Q9)** ❑ Rental by client, no ongoing housing subsidy ❑ **Rental by client, with ongoing housing subsidy** ***[collect additional info below]*** ❑ Owned by client, with ongoing housing subsidy ❑ Owned by client, no ongoing housing subsidy **Other** ❑ Client doesn't know ❑ Client prefers not to answer
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) _____

7) Length of stay in prior living situation [Head of Household and Adults] *How long have you been sleeping/staying where you stayed/slept last night? If the client stayed in situation in the same type of place, but not exactly the same place, include the total time in that type of situation, (e.g., slept in different hotels).*	❑ 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
8) If the client stayed in an Institutional Situation last night, was the stay less than 90 days? **If the response is "Yes", did the client stay on the streets or in emergency shelter the night before going to the institutional situation?**	❑ Yes ❑ No ❑ Not Applicable ❑ Yes ❑ No
9) If the client stayed in Transitional/Permanent housing last night, was the stay less than 7 days? **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?**	❑ Yes ❑ No ❑ Not Applicable ❑ Yes ❑ No
10) Approximate date *<u>this episode</u>* of homelessness started: [Head of Household and Adults] *When was the date your current episode of homelessness 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).*	❑ Not Applicable | | | / | | | / | | | | | This information can be by client self-report

Client Name _____

Head of Household Name (if not Self) _____

11) Number of separate times (episodes) the client has been on the streets or in Emergency Shelter in the <u>past three years</u> including today [Head of Household and Adults]	❑ One Time ❑ Two Times ❑ Three Times	❑ Four or more times ❑ Client doesn't know ❑ Client prefers not to answer
12) Total number of months client has been homeless on the streets or in Emergency Shelter in the <u>past three years</u> [Head of Household and Adults]	❑ One month (this time is the first month) ❑ 2 months ❑ 3 months ❑ 4 months ❑ 5 months ❑ 6 months ❑ 7 months ❑ 8 months ❑ 9 months ❑ 10 months ❑ 11 months	❑ 12 months ❑ More than 12 months ❑ Client doesn't know ❑ Client prefers not to answer

Disabling Conditions (All Responses required)

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
2) Does the client have a Physical Disability? *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 ❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer ❑ Client doesn't know ❑ Client prefers not to answer
3) Does the client have a Developmental Disability?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer

Client Name _____

Head of Household Name (if not Self) _____

4) Does the client have a Chronic Health Condition?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer
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
5) Does the client have HIV – AIDS? *If **Yes**, please be sure to answer the required HIV/AIDS questions below.*	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer
6) Does the client have a Mental Health Disorder?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer
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
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
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

Domestic Violence [Head of Household and Adults]

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

Client Name _____

Head of Household Name (if not Self) _____

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
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 ❑ Client doesn't know ❑ No ❑ Client prefers not to answer

Monthly Income – Cash Benefits [Head of Household and Adults]

Current income from any source? *Is the client currently receiving any income from any source?*	❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer
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 Cash Income for Individual	**TOTAL**: $_____

Client Name _____

Head of Household Name (if not Self) _____

Non-Cash Benefits [Head of Household and Adults]

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
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: _____

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
If Yes, type(s) of insurance(s) and reason(s) not covered: *If the client is currently covered by multiple health insurances please select all that apply.*	❑ Medicaid (same as Medi-Cal) ❑ Applied; Decision Pending ❑ Applied; Client Not Eligible ❑ Client Did Not Apply ❑ Insurance Type N/A for this Client ❑ Client doesn't know ❑ Client prefers not to answer
	❑ Medicare ❑ Applied; Decision Pending ❑ Applied; Client Not Eligible ❑ Client Did Not Apply ❑ Insurance Type N/A for this Client ❑ Client doesn't know ❑ Client prefers not to answer
	❑ State Children's Health Insurance (CHIP) Program ❑ Applied; Decision Pending ❑ Applied; Client Not Eligible ❑ Client Did Not Apply ❑ Insurance Type N/A for this Client ❑ Client doesn't know ❑ Client prefers not to answer

Client Name _____

Head of Household Name (if not Self) _____

	❑ Veteran's Health Administration (VHA) ❑ Applied; Decision Pending ❑ Applied; Client Not Eligible ❑ Client Did Not Apply ❑ Insurance Type N/A for this Client ❑ Client doesn't know ❑ Client prefers not to answer
	❑ Employer-Provided Health Insurance ❑ Applied; Decision Pending ❑ Applied; Client Not Eligible ❑ Client Did Not Apply ❑ Insurance Type N/A for this Client ❑ Client doesn't know ❑ Client prefers not to answer
	❑ Health Insurance Obtained Through COBRA ❑ Applied; Decision Pending ❑ Applied; Client Not Eligible ❑ Client Did Not Apply ❑ Insurance Type N/A for this Client ❑ Client doesn't know ❑ Client prefers not to answer
	❑ Private Pay Health Insurance ❑ Applied; Decision Pending ❑ Applied; Client Not Eligible ❑ Client Did Not Apply ❑ Insurance Type N/A for this Client ❑ Client doesn't know ❑ Client prefers not to answer
	❑ State Health Insurance for Adults ❑ Applied; Decision Pending ❑ Applied; Client Not Eligible ❑ Client Did Not Apply ❑ Insurance Type N/A for this Client ❑ Client doesn't know ❑ Client prefers not to answer
	❑ Indian Health Services Program ❑ Applied; Decision Pending ❑ Applied; Client Not Eligible ❑ Client Did Not Apply ❑ Insurance Type N/A for this Client ❑ Client doesn't know ❑ Client prefers not to answer
	❑ Other Health Insurance If Other Specify: _____

Client Name _____

Head of Household Name (if not Self) _____

Medical Assistance [All Household Members with HIV/AIDS]

Is the client receiving AIDS Drug Assistance Program (ADAP)?	❑ No ❑ Yes ❑ Client doesn't know ❑ Client prefers not to answer
If No for "Receiving AIDS Drug Assistance Program (ADAP)," please select the appropriate reason:	❑ Applied; decision pending ❑ Applied; client not eligible ❑ Client did not apply ❑ Insurance type N/A for this client ❑ Client doesn't know ❑ Client prefers not to answer
Is the client receiving Ryan White-funded Medical or Dental Assistance?	❑ No ❑ Yes ❑ Client doesn't know ❑ Client prefers not to answer
If No for "Receiving Ryan White-funded Medical or Dental Assistance," please select the appropriate reason:	❑ Applied; decision pending ❑ Applied; client not eligible ❑ Client did not apply ❑ Insurance type N/A for this client ❑ Client doesn't know ❑ Client prefers not to answer

T-cell (CD4) and Viral Load [All Household Members with HIV/AIDS]

T-Cell (CD4) Count Available?	❑ No ❑ Yes ❑ Client doesn't know ❑ Client prefers not to answer
If Yes to "T-Cell (CD4) Count Available," then please collect the T-cell Count number: *Integer between 0-1500*	
If a number is entered in the T-Cell (CD4) count, then how was the information obtained?	❑ Medical Report ❑ Client Report ❑ Other
Viral Load Information Available?	❑ Not Available ❑ Available ❑ Undetectable ❑ Client doesn't know ❑ Client prefers not to answer
If "Viral Load Information Available," then please collect the Viral Load Count: *Integer between 0-999999*	
If a number is entered in the Viral Load count, then how was the information obtained?	❑ Medical Report ❑ Client Report ❑ Other

Client Name _____

Head of Household Name (if not Self) _____

Prescribed Anti-Retroviral [All Household Members with HIV/AIDS]

Has the participant been prescribed anti-retroviral drugs?	❑ No ❑ Yes ❑ Client doesn't know ❑ Client prefers not to answer

Sexual Orientation [Head of Household and Adults]

What is the client's sexual orientation?	❑ Heterosexual ❑ Gay ❑ Lesbian ❑ Bisexual ❑ Questioning/Unsure ❑ Other (please specify)	❑ Client doesn't know ❑ Client prefers not to answer

General Health Status [Head of Household and Adults]

What is the client's general health status?	❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor	❑ Client doesn't know ❑ Client prefers not to answer

Employment Status [Head of Household and Adults]

Currently Employed? *Is the client currently employed?*	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer
If Yes, specify the type of employment	❑ Full-time ❑ Part-time ❑ Seasonal/Sporadic (including day labor)	
If No, is the client looking for employment?	❑ Looking for work ❑ Unable to work ❑ Not looking for work	

Client Name _____

Head of Household Name (if not Self) _____

Education Status [Head of Household and Adults]

Specify the last grade of school completed by the client	❑ Less than Grade 5 ❑ Grades 5-6 ❑ Grades 7-8 ❑ Grades 9-11 ❑ Grade 12/ High school diploma ❑ School program does not have grade levels	❑ GED ❑ Some college ❑ Associate's degree ❑ Bachelor's degree ❑ Graduate degree ❑ Vocational certification ❑ Client doesn't know ❑ Client prefers not to answer
Is the client currently enrolled in school or a training program?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer
If Yes, specify the type of school or training program	❑ High School ❑ Community College ❑ Vocational Program	❑ Training Program ❑ University ❑ Other

Last Permanent Address [Head of Household and Adults]

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

Client Name _____

Head of Household Name (if not Self) _____