

Eastern PA CoC Coordinated Entry Intake

HMIS ID:

| | | | | | | | | | | | | | | | | |
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SHELTER REFERRALS: YES

NO

CE INTAKE DATE:

| | | | | | |
|---|---|---|---|---|---|
| M | M | D | D | Y | Y |
|---|---|---|---|---|---|

NAME (NON-ANONYMOUS ONLY):

| | | | | | | | | | | | | | | | | | | | |
|-------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| First name | | | | | | | | | | | | | | | | | | | |
| Middle name | | | | | | | | | | | | | | | | | | | |
| Last name | | | | | | | | | | | | | | | | | | | |

PASSCODE: For DV clients who wish to be entered into the system anonymously

Please remind the client they will need to keep this passcode in a secure, accessible location or be able to remember it easily as agencies will ask for it when they reach out.

| | | | | | | | | | | | | | | | | | | | |
|-------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Client Created Passcode | | | | | | | | | | | | | | | | | | | |
|-------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|

CONTACT INFORMATION

| | |
|---|--|
| Primary Phone Number & Type (Personal, Family/Friend, Case Manager) | |
| Secondary Phone Number & Type (Personal, Family/Friend, Case Manager) | |
| Email Address | |

SAFETY PLAN FOR PROVIDER COMMUNICATION

| | |
|---|--|
| Safe to Call Client? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Safe to Leave Voicemail? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Safe to Text Client? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Safe to Identify Provider/Agency Upon Calling? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Additional Contact Safety Concerns/Notes? (For example, does anyone else have access to this phone; are certain times or days not safe to call) | |

DV CONSENT QUESTION FOR HMIS PARTICIPATION:

Do I have your permission to enter your information in our secure data system called HMIS, share it with Coordinated Entry referral partners, and place your information onto the prioritization list for housing services? If you have elected to be anonymous, your phone number will be secured in a protected location and not entered into the main HMIS system.

CLIENT CONSENTED? Yes No

BASIC CLIENT INFORMATION

| | | | | | | | |
|--|--|---|---|---|---|---|---|
| DOB: Non-Anonymous Clients | <table border="1"> <tr> <td>M</td> <td>M</td> <td>D</td> <td>D</td> <td>Y</td> <td>Y</td> </tr> </table> | M | M | D | D | Y | Y |
| M | M | D | D | Y | Y | | |
| <p>"Have you or any other household member served as active duty in the United States military, including the Army, Navy, Air Force, Marine Corps, Coast Guard, Reserves, or National Guard? You may choose to refuse to answer if you feel that it is potentially identifying."</p> <p>If yes, would the client like referrals sent to Veteran Providers?</p> | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Refused/Anonymous Client <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| Age Range: Anonymous Clients | <input type="checkbox"/> 18-24 <input type="checkbox"/> 25-30 <input type="checkbox"/> 31-54 <input type="checkbox"/> 55-59 <input type="checkbox"/> 60 and over | | | | | | |
| Race: Does not get collected for DV Anon Clients | <input type="checkbox"/> American Indian, Alaska Native, or Indigenous <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black, African American, or African <input type="checkbox"/> Hispanic/Latina/e/o <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected | | | | | | |
| Gender | <input type="checkbox"/> Woman <input type="checkbox"/> Man <input type="checkbox"/> Culturally Specific Identity (e.g., Two Spirit) <input type="checkbox"/> Transgender <input type="checkbox"/> Non-Binary <input type="checkbox"/> Questioning <input type="checkbox"/> Different Identity <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected | | | | | | |

LOCATION SLEPT LAST NIGHT, PRIOR TO ENTRY If known and client is willing to provide the information

| | |
|----------|--|
| City | |
| State | |
| Zip Code | |

ADDITIONAL COMMENTS/INFORMATION:

DOMESTIC VIOLENCE ASSESSMENT

Survivor of Domestic Violence:

- Yes
- No
- Client doesn't know
- Client prefers not to answer
- Data Not Collected

Currently Fleeing:

- Yes
- No
- Client doesn't know
- Client prefers not to answer
- Data Not Collected

TRANSLATION ASSISTANCE ASSESSMENT

Translation Assistance Needed?

- YES
- NO

If yes, please include the client's preferred language.

Preferred Language: _____

TRIAGE ASSESSMENT

MENTAL HEALTH DIAGNOSIS

"Do you have a mental health condition, concern, or other diagnosis which impedes your ability to maintain housing or employment?"

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

MEDICAID QUESTION

Do you or another household member currently receive Medicaid benefits from the State of Pennsylvania?

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

*If prompted: Medicaid covers a broad range of physical and behavioral health services, including doctor visits when you're sick, preventative care like health screenings, vaccines, hospital stays, prescription medications, mental health and substance use disorder care, and more.

ADDITIONAL HOUSEHOLD MEMBERS

| | | | | | | | |
|--|--|---|---|---|---|---|---|
| First name | | | | | | | |
| Last name | | | | | | | |
| DOB | <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; text-align: center;">M</td> <td style="width: 20px; text-align: center;">M</td> <td style="width: 20px; text-align: center;">D</td> <td style="width: 20px; text-align: center;">D</td> <td style="width: 20px; text-align: center;">Y</td> <td style="width: 20px; text-align: center;">Y</td> </tr> </table> | M | M | D | D | Y | Y |
| M | M | D | D | Y | Y | | |
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| Veteran Status | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| Disabling Condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No Notes: | | | | | | |
| Relationship to Head of Household: | | | | | | | |
| Race: Does not get collected for DV Anon Clients | <input type="checkbox"/> American Indian, Alaska Native, or Indigenous <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black, African American, or African <input type="checkbox"/> Hispanic/Latina/e/o <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected | | | | | | |

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UNIVERSAL DATA ASSESSMENT

DISABLING CONDITION

"Do you or any member of your family have a disabling condition which consists of any physical, mental, or emotional impairment, including an impairment caused by substance use disorder, or a brain injury that impedes your ability to maintain housing or employment?"

- Yes
- No
- Client prefers not to answer

PRIOR LIVING SITUATION: Where the client slept last night.

Homeless Situation

- Place not meant for habitation
- Emergency shelter, including hotel/motel paid for with emergency shelter voucher or RHY-funded Host Home
- Safe Haven

Institutional Situation

- 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

Transitional and Permanent Housing Situation

- Residential project or halfway house with no homeless criteria
- Hotel/motel paid for without emergency shelter voucher
- Rental by client, with VASH housing subsidy
- Transitional housing for homeless persons (includes homeless youth)
- Host-home (non-crisis)
- Staying/living in a friend's room, apartment, or house
- Staying/living in a family member's room, apartment, or house
- Rental by client, with GPD TIP housing subsidy
- Permanent housing (other than RRH) for formerly homeless persons
- Rental by client, with RRH or equivalent subsidy
- Rental by client, with HCV voucher (tenant or project based)
- Rental by client, in a public housing unit
- Rental by client, no ongoing housing subsidy
- Rental by client, with other ongoing housing subsidy
- Owned by client, with ongoing housing subsidy
- Owned by client, no ongoing housing subsidy

Other

- Client doesn't know
- Client refused
- Worker unable to determine
- Data not collected

Is the client housed but not safe due to current DV concerns: Yes No

LENGTH OF STAY IN THE 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

TOTAL NUMBER OF TIMES THE CLIENT HAS BEEN ON THE STREETS, IN EMERGENCY SHELTER, OR SAFE HAVEN IN THE PAST THREE YEARS INCLUDING TODAY:

- One time
- More than once: _____
- Client doesn't know
- Client refused

TOTAL NUMBER OF MONTHS HOMELESS ON THE STREET, IN EMERGENCY SHELTER, OR SAFE HAVEN IN THE PAST THREE YEARS:

- This is the first month
- Number of months _____
- Client doesn't know
- Client prefers not to answer

DOES THE CLIENT HAVE TO LEAVE THEIR CURRENT LIVING SITUATION WITHIN 14 DAYS (THIS MAY BE FOR LEASE OR LEGAL REASONS OR IT MAY BE DUE TO SAFETY/DV RELATED CONCERNS)

- YES
- NO

HAS A SUBSEQUENT RESIDENCE BEEN IDENTIFIED?

- YES
- NO

DOES INDIVIDUAL OR FAMILY HAVE RESOURCES OR SUPPORT NETWORKS TO OBTAIN OTHER PERMANENT HOUSING?

- YES
- NO

HAS THE CLIENT HAD A LEASE OR OWNERSHIP INTEREST IN A PERMANENT HOUSING UNIT IN THE LAST 60 DAYS?

- YES
- NO

HAS THE CLIENT MOVED 2 OR MORE TIMES IN THE LAST 60 DAYS?

- YES
- NO

COUNTY OR COUNTIES WHERE ASSISTANCE IS PREFERRED

If client states "anywhere", you may wish to discuss issues related to relocation. For example, would they have transportation to get "anywhere"? Do they want to be close to resources, a support network, work, or family members in a specific area?

NUMBER OF BEDROOMS NEEDED: _____

HOUSING ASSESSMENT TOOL (HAT)

ASSESSMENT DATE: _____

HAS YOUR CURRENT LIVING SITUATION MADE IT DIFFICULT FOR ANY SCHOOL-AGED CHILDREN IN YOUR HOUSEHOLD TO ATTEND OR DO WELL IN SCHOOL?

- Yes
- No
- Client prefers not to answer

IS YOUR CURRENT EXPERIENCE OF HOMELESSNESS THE RESULT IN WHOLE OR IN PART DUE TO DISCRIMINATION?

- Yes
- No
- Client prefers not to answer

IF YES, WHAT KIND(S) OF DISCRIMINATION? (THIS SHOULD NOT BE ASKED, ONLY DOCUMENT IF THE CLIENT DISCLOSES THE INFORMATION.)

- Racial/Ethnic
- Gender
- Sexual
- Religion
- Client doesn't know
- Family Composition
- Income
- Pets
- Other: _____
- Client prefers not to answer

IS YOUR CURRENT EXPERIENCE OF HOMELESSNESS THE RESULT IN WHOLE OR IN PART DUE TO CRIMINAL BACKGROUND OR JUSTICE SYSTEM INVOLVEMENT?

- Yes
- No
- Client prefers not to answer

IF YES, WHAT KIND(S) OF CRIMINAL BACKGROUND OR JUSTICE SYSTEM INVOLVEMENT? (THIS SHOULD NOT BE ASKED, ONLY DOCUMENT IF THE CLIENT DISCLOSES THE INFORMATION.)

- Felony Conviction
- Criminal Charges (No Conviction)
- Other
- Client prefers not to answer
- Misdemeanor Conviction
- Probation
- Client doesn't know

HAVE YOU BEEN EVICTED FROM A HOUSING UNIT (RENTAL OR HOME OWNERSHIP) IN THE PAST (7) YEARS?

- Yes
- No
- Client prefers not to answer

SINCE BECOMING HOMELESS, HAS ANYONE IN YOUR HOUSEHOLD BEEN ENGAGED IN DANGEROUS OR ILLEGAL ACTIVITIES?

- Yes
- No
- Client prefers not to answer