HMIS Intake and Enrollment Form

Client Name / ID: _____

Identification *- All fields required unless otherwise noted*

HMIS consent? ☐ No (refused) ☐ Written ☐ Verbal (HFSS only) If verbal: Agency_____ Staff_____ Date _____

First Name: _____ **Middle Name** (Optional)**:** _____

Last Name: _____ **Suffix** (Optional)**:** _____

Name Data Quality: Did the client provide their full name?	**Physical Description** (Optional)**:**	**Last Known Permanent Address:** Where have you last lived for 90 days or more? (Not including emergency shelters and transitional housing)
☐ Full Name Reported ☐ Partial, street name, or code name reported ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected		Address: _____ City: _____ County: _____ State: _____ Zip: _____ Address Quality: ☐ Full Address Reported ☐ Incomplete or Estimated Address Reported ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected
Date of Birth:	**SSN:**	
_____/_____/_____ ☐ Full DOB reported ☐ Approximate or partial DOB reported ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	_____-_____-_____ ☐ Full SSN reported ☐ Approximate or partial SSN reported ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	

Contact Information *- Optional but extremely helpful*

Phone Number (*Do you have a number and email where I can follow-up with you or leave a message?)*			**Phone Type**		**Contact Preference**
Main: (_____)_____-_____ x_____ ☐ Leave message			☐ Home ☐ Work ☐ Cell ☐ Message Center		☐ Phone ☐ Text ☐ Email
Alternate:(_____)_____-_____ x_____ ☐ Leave message			☐ Home ☐ Work ☐ Cell ☐ Message Center		
Email	_____@_____	**Notes**			

Demographics *- All fields required unless otherwise noted*

Housing Status:		**Family Type:**
☐ Category 1 - Homeless ☐ Category 2 – At Imminent Risk of Losing Housing (within 14 days or less) ☐ Category 3 – Homeless only under other Federal Statutes ☐ Category 4 – Fleeing Domestic Violence ☐ At Risk of Homelessness ☐ Stably Housed	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	☐ Unaccompanied ☐ Single Parent ☐ Two Parents ☐ Adults No children

TB Clearance Date (Optional)	**Clinic Providing Clearance** (Optional)

HMIS Intake and Enrollment Form

Client Name / ID: _____

Relation *(to Head of Household)*	**Gender:**	
☐ Self	☐ Male	☐ Client Doesn't Know
☐ Head of Household's Child	☐ Female	☐ Client Refused
☐ Head of Household's Spouse or Partner	☐ Transgender Female to Male	☐ Data not Collected
☐ Head of Household's other Relation Member	☐ Transgender Male to Female	
☐ Other: Non-relation Member	☐ Other (Specify:_____)	

Disabled? *(Physical, Developmental, Mental Health, Chronic Health Condition, HIV/AIDS, and/or Substance Use Disorder.)*	**Veteran** (Have you ever served in the U.S. Military?)	**Education Level** (What is the highest level of education you've completed?)	
☐ Yes	☐ Yes*	☐ No Schooling Completed	☐ 12th Grade, no diploma
☐ No	☐ No	☐ Nursery School to 4th Grade	☐ High School Diploma
☐ Client Doesn't Know	☐ Client Doesn't Know	☐ 5th or 6th Grade	☐ GED
☐ Client Refused	☐ Client Refused	☐ 7th or 8th Grade	☐ Post-Secondary School
☐ Data not Collected	☐ Data not Collected	☐ 9th Grade	☐ 4-year College Degree
	**If yes, please administer VA release of information*	☐ 10th Grade	☐ Graduate School
		☐ 11th Grade	☐ Unknown

Insurance (Health Insurance Provider) (Check all that apply)		**Ethnicity**	**Residency Status**
☐ HealthNet	☐ L.A. Care	☐ Non-Hispanic	☐ Citizen
☐ Anthem Blue Cross	☐ L.A. Care Health Plan	☐ Hispanic	☐ Permanent Legal Resident
☐ Kaiser Permanente	☐ L.A. Care Health Partners	☐ Client Doesn't Know	☐ Asylee, Refugee, or other Eligible Immigrant
☐ VA	☐ Other	☐ Client Refused	☐ Ineligible Immigrant
☐ Care 1st Health Plan	☐ Unknown	☐ Data not Collected	☐ Client Doesn't Know
	☐ None		☐ Client Refused

Race (Check all that apply)				
☐ Asian	☐ Black or African American	☐ Data not Collected ☐ Native Hawaiian or Other Pacific Islander	☐ Client Doesn't Know ☐ American Indian or Alaska Native	☐ Client Refused ☐ White

Income and Insurance *- All fields required unless otherwise noted*

DPSS ID (Optional): _____ ☐ GAIN Participant (Optional)

Income Source (Check all that apply)	**Stated Income**	**Pay Interval**					
		Weekly	Every Other Week	Twice A Month	Monthly	Quarterly	Yearly
☐ No financial resources	$	☐	☐	☐	☐	☐	☐
☐ Earned Income *(employment wages / cash)*	$	☐	☐	☐	☐	☐	☐
☐ Unemployment Insurance	$	☐	☐	☐	☐	☐	☐
☐ Supplemental Security Income (SSI)	$	☐	☐	☐	☐	☐	☐
☐ Social Security Disability Income (SSDI)	$	☐	☐	☐	☐	☐	☐
☐ VA Service-Connected Disability Compensation	$	☐	☐	☐	☐	☐	☐
☐ VA Non-Service-Connected Disability Pension	$	☐	☐	☐	☐	☐	☐
☐ Private Disability Insurance	$	☐	☐	☐	☐	☐	☐
☐ Workers Compensation	$	☐	☐	☐	☐	☐	☐
Continued on Next Page →							

HMIS Intake and Enrollment Form

Client Name / ID: _____

☐ Temporary Assistance for Needy Families *(CalWORKs)*	$	☐	☐	☐	☐	☐	☐	
☐ General Assistance (GA) *(General Relief (GR))*	$	☐	☐	☐	☐	☐	☐	
☐ Retirement Income from Social Security	$	☐	☐	☐	☐	☐	☐	
☐ Pension or retirement income from a former job	$	☐	☐	☐	☐	☐	☐	
☐ Child Support	$	☐	☐	☐	☐	☐	☐	
☐ Alimony or other spousal support	$	☐	☐	☐	☐	☐	☐	
☐ Other Source (Specify:_____)	$	☐	☐	☐	☐	☐	☐	
☐ Client Doesn't Know								
☐ Client Refused								
☐ Data not Collected								

Income Documentation (Optional):			**Comments** (Optional)**:**
☐ GR Form	☐ CalWORKs Form	☐ Pension Letter/Stub	
☐ Pay Stub	☐ Unemployment Insurance Forms	☐ Unemployment Forms	
☐ Utility Allowance	☐ W-2 Forms	☐ Self Declaration	
☐ Child Support Forms	☐ SSDI Form	☐ Employer Printout/Letter	
☐ Social Security Forms	☐ Workmans Comp	☐ VA Documentation	
☐ SSI Forms	☐ Self Employment Docs		

Non-Cash Benefits (Check all that apply):			
☐ None	☐ Client Doesn't Know	☐ Client Refused	☐ Data not Collected
☐ Food Stamps (CalFresh) Amount: _____	☐ CalWorks Child Care	☐ Temporary Rental Assistance	
	☐ CalWorks Transportation	☐ Section 8 or Rental Assistance	☐ Medically Needy Amount: _____
☐ WIC	☐ Other CalWorks-Funded Services	☐ Other _____	

Health Insurance (Check all that apply)**:**			
☐ No Health Insurance	☐ Client Doesn't Know	☐ Client Refused	☐ Data not Collected
☐ MEDICAID	☐ MEDICARE	☐ State Children's Health Ins.	☐ VA Medical Services
☐ Employer Provided Health Ins.	☐ COBRA Health Ins.	☐ Private Health Ins.	☐ MediCal

Location Information *- Optional*

Location Type: On a regular day, where is it easiest to find you?	**Address Type** (Enter one: Address, Intersection, or Landmark)**:**
☐ Street ☐ Vehicle ☐ Abandoned building ☐ Bus/train/subway station/airport ☐ Drop in center ☐ Day services center ☐ Soup kitchen ☐ Emergency Shelter ☐ Transitional Housing ☐ Permanent Housing ☐ Clinic/Hospital - Health ☐ Clinic/Hospital – Mental Health ☐ Clinic/Hospital – Substance Abuse ☐ Jail, prison, or juvenile detention facility ☐ Family or friend's room, apartment, condo, or house ☐ Foster care or group home	Address: _____ Intersection: _____ and _____ Landmark: _____ **City, County, State, and Zip** (Enter all)**:** City: _____ County: _____ State: _____ Zip: _____ Zip Quality: ☐ Full ☐ Client Refused ☐ Client Doesn't Know ☐ Data not Collected

HMIS Intake and Enrollment Form

Client Name / ID: _____

Documentation *- Optional*

Document Type	Obtained Date (If applicable)	Document Status: (If applicable)			Expiration Date (If applicable)
		N/A	Need	Have	
☐ Birth Certificate		☐	☐	☐	
☐ Certificate of Disability		☐	☐	☐	
☐ DD214 (Veterans Only)		☐	☐	☐	
☐ Driver's License / CA ID		☐	☐	☐	
☐ Homeless Verification		☐	☐	☐	
☐ Proof of Residency		☐	☐	☐	
☐ Reference Letter		☐	☐	☐	
☐ Social Security Card		☐	☐	☐	
☐ TB Certification		☐	☐	☐	
☐ Verification of Income		☐	☐	☐	
☐ VA Release		☐	☐	☐	
☐ LACDMH 677 Authorization Consent		☐	☐	☐	
☐ DHS Pre-release		☐	☐	☐	
☐ Other: _____		☐	☐	☐	

Client Note *- Optional*

Client Note:	
Type: ☐ Information ☐ Alert	
Private Customer: ☐ Yes ☐ No	
Note Date: ____/____/____	

Emergency Contact Information *- Optional*

Contact Type	Phone Number	Phone Type	Email
Alternate Contact *(Who is the best person to get in touch with you?)* Relationship: _____ First Name: _____ Last Name: _____	(_____)_____-_____ x_____	☐ Home ☐ Cell ☐ Work ☐ Message Center	
Emergency Contact *(In case of an emergency, who should we alert?)* ☐ Same as above Relationship: _____ First Name: _____ Last Name: _____	(_____)_____-_____ x_____	☐ Home ☐ Cell ☐ Work ☐ Message Center	

HMIS Intake and Enrollment Form

Client Name / ID: _____

Program Entry *- All fields required unless otherwise noted*

Program Name: _____ **Program Entry Date:** _____/_____/_____

Case Manager: _____

1. Where did you sleep last night?

- ☐ Emergency shelter
- ☐ Foster care home or foster care group home
- ☐ Hospital or other residential non-psychiatric medical facility*
- ☐ Hotel or motel paid for without emergency shelter voucher
- ☐ Jail, prison or juvenile detention facility*
- ☐ Long-term care facility or nursing home
- ☐ Owned by client, no ongoing housing subsidy
- ☐ Owned by client, with ongoing housing subsidy
- ☐ Permanent housing for formerly homeless persons
- ☐ Place not meant for habitation
- ☐ Psychiatric hospital or other psychiatric facility*
- ☐ Rental by client, no ongoing housing subsidy
- ☐ Rental by client, with VASH housing subsidy
- ☐ Rental by client, with GPD TIP subsidy
- ☐ Rental by client, with other (non-VASH) ongoing housing subsidy
- ☐ Residential project or halfway house with no homeless criteria
- ☐ Safe Haven
- ☐ Staying or living in a family member's room, apartment, or house
- ☐ Staying or living in a friend's room, apartment or house
- ☐ Substance abuse treatment facility or detox center*
- ☐ Transitional housing for homeless persons
- ☐ Other
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data not Collected

1a. If "Other" prior residence was selected, please specify (Required only if question #1 was answered as "Other")

2. How long was your stay?

- ☐ One day or less*
- ☐ Two days to one week*
- ☐ More than one week, but less than one month*
- ☐ One to three months*
- ☐ More than three months, but less than one year
- ☐ One year or longer
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data not Collected

3. Client entering from the streets, ES (Emergency Shelter), or SH (Safe Haven)?

- ☐ No
- ☐ Yes
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data not Collected

3a. Approximate date started (Required only if question #3 was answered as "Yes")

_____/_____/_____

4. Number of times the client has been on the streets, in ES, or SH in the past three years including today

- ☐ Never in the 3 years
- ☐ One Time
- ☐ Two Times
- ☐ Three Times
- ☐ Four or more times
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data not Collected

4a. Total number of months homeless on the street, in ES, or SH in the past three years (Required only if question #4 was answered as anything *other* than "Never in the 3 years")

- ☐ One month (this time is the first month)
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ 11
- ☐ 12
- ☐ More than 12 months
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data not Collected

HMIS Intake and Enrollment Form

Client Name / ID: _____

HOMELESSNESS *- Adults aged 18 and older and Head of Household < 18 years old, required questions are shaded*

Question	Check One Answer	Comments
If question #2 was answered as three months or less (*) AND question #1 was answered as one of the following (*): -"Hospital or other residential non-psychiatric medical facility" -"Jail, prison or juvenile detention facility" -"Psychiatric hospital or other psychiatric facility" -"Substance abuse treatment facility or detox center" Then the following question is required:		
5. Where were you sleeping prior to entering the institutional setting mentioned above (in question #1)?	□ Emergency shelter □ Foster care home or foster care group home □ Hospital or other residential non-psychiatric medical facility □ Hotel or motel paid for without emergency shelter voucher □ Jail, prison or juvenile detention facility □ Long-term care facility or nursing home □ Owned by client, no ongoing housing subsidy □ Owned by client, with ongoing housing subsidy □ Permanent housing for formerly homeless persons □ Place not meant for habitation □ Psychiatric hospital or other psychiatric facility □ Rental by client, no ongoing housing subsidy □ Rental by client, with VASH housing subsidy □ Rental by client, with GPD TIP subsidy □ Rental by client, with other (non-VASH) ongoing housing subsidy □ Residential project or halfway house with no homeless criteria □ Safe Haven □ Staying or living in a family member's room, apartment, or house □ Staying or living in a friend's room, apartment or house □ Substance abuse treatment facility or detox center □ Transitional housing for homeless persons □ Other □ Client Doesn't Know □ Client Refused □ Data not Collected	

WELLNESS *– All clients, required questions are shaded*

Question	Check One Answer	Comments
6. Have you been diagnosed with AIDS or have you tested positive for HIV?	□ No □ Yes***** □ Client Doesn't Know □ Client Refused □ Data not Collected	
If question #6 was answered as "Yes" (*****), then the following questions are **required**:		
6a. Do you expect this to substantially impair your ability to live independently?	□ No □ Yes □ Client Doesn't Know □ Client Refused □ Data not Collected	
6b. Do you have documentation of the disability and severity on file?	□ No □ Yes	
6c. Are you currently receiving services or treatment for this condition?	□ No □ Yes □ Client Doesn't Know □ Client Refused □ Data not Collected	

HMIS Intake and Enrollment Form

Client Name / ID: _____

7. Do you have a chronic health condition? *A Chronic Health Condition is defined as a diagnosed condition that is more than 3 months in duration and is either not curable or has residual effects that limit daily living and require adaptation in function or special assistance. Examples of chronic health conditions include, but are not limited to:* ***heart disease*** *(including coronary heart disease, angina, heart attack and any other kind of heart condition or disease);* ***severe asthma****; diabetes;* ***arthritis-related conditions*** *(including arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia);* ***adult onset cognitive impairments*** *(including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive related conditions);* ***severe headache/migraine****;* ***cancer****;* ***chronic bronchitis****;* ***liver condition; stroke****; or* ***emphysema****.*	☐ No ☐ Yes* ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
If question #7 was answered as "Yes" (*), then the following questions are **required**:		
7a. Is this temporary, or do you expect this to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
7b. Do you have documentation of the disability and severity on file?	☐ No ☐ Yes	
7c. Are you currently receiving services or treatment for this condition?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
8. Do you have a physical disability?	☐ No ☐ Yes* ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
If question #8 was answered as "Yes" (*), then the following questions are **required**:		
8a. Is this temporary, or do you expect this to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
8b. Do you have documentation of the disability and severity on file?	☐ No ☐ Yes	
8c. Are you currently receiving services or treatment for this condition?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
9. Do you *currently* have a drug or alcohol problem?	☐ No ☐ Alcohol* ☐ Drug* ☐ Both* ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
If question #9 was answered as "Alcohol", "Drug", or "Both" (*), then the following questions are **required**:		
9a. Is this temporary, or do you expect this to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
9b. Do you have documentation of the disability and severity on file?	☐ No ☐ Yes	
9c. Are you currently receiving services or treatment for this condition?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	

HMIS Intake and Enrollment Form

Client Name / ID: _____

10. Have you ever been told you have a learning disability or developmental disability?	☐ No ☐ Yes* ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
If question #10 was answered as "Yes" (*), then the following questions are **required**:		
10a. Is this temporary, or do you expect this to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
10b. Do you have documentation of the disability and severity on file?	☐ No ☐ Yes	
10c. Are you currently receiving services or treatment for this condition?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
11. Do you feel you currently have a mental health problem?	☐ No ☐ Yes* ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
If question #11 was answered as "Yes" (*), then the following questions are **required**:		
11a. Is this temporary, or do you expect this to be of long–continued and indefinite duration AND substantially impair your ability to live independently?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
11b. Do you have documentation of the disability and severity on file?	☐ No ☐ Yes	
11c. Are you currently receiving services or treatment for this condition?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
12. Have you been a victim of domestic violence or a victim of intimate partner violence?	☐ No ☐ Yes* ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
If question #12 was answered as "Yes" (*), then the following question is **required**:		
12a. How long ago did you have this experience?	☐ Within the past three months ☐ Three to six months ago (excluding six months exactly) ☐ From six to twelve months ago (excluding one year exactly) ☐ More than a year ago ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
12b. Are you currently fleeing?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	

HMIS Intake and Enrollment Form

Client Name / ID: _____

TUBERCULOSIS *– Emergency Shelters and Winter Shelters only, required questions shaded*

Question	Check One Answer		Comments
13. Do you have a cough that has lasted longer than 3 weeks?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused	
14. Have you recently lost weight without explanation during the past month?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused	
15. Have you had frequent night sweats during the past month, soaking your sheets or clothing?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused	
16. Have you coughed up blood in the past month?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused	
17. Have you been feeling much more tired than usual over the past month?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused	
18. Have you had fevers almost daily for more than one week?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused	

EMPLOYMENT *- For adults18 and older or Head of Household < 18 years old, required questions shaded*

Question	Check One Answer		Comments
19. Are you currently employed?	☐ No* ☐ Yes**	☐ Client Doesn't Know ☐ Client Refused	
If question #19 was answered as "No" (*), then the following question is **required**:			
19a. Why are you not employed?	☐ Looking for work ☐ Unable to work ☐ Not looking for work		
If question #19 was answered as "Yes" (**), then the following question is **required**:			
19b. What type of employment do you have?	☐ Full-time ☐ Part-time ☐ Seasonal / sporadic (including day labor)		

INCOME *- Adults aged 18 and older having **NO** financial resources only*

Question	Check One Answer		Comments
20. If you do not have an income, and are unable to receive general relief, what's the reason why?	☐ Sanctioned ☐ Time Limits ☐ Employment	☐ Other	

PREGNANCY *- Women aged 15 and older only*

Question	Check One Answer		Comments
21. Are you pregnant?	☐ No ☐ Yes*	☐ Client Doesn't Know ☐ Client Refused	
If question #21 was answered as "Yes" (*), then the following question is **required**:			
21a. What is your due date?	___/___/_____		

YOUTH *- Head of Households aged 17 and under only*

Question	Check One Answer		Comments
22. Did you run away from home or a foster care home?	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused	

HMIS Intake and Enrollment Form

Client Name / ID: _____

TRANSITION AGE YOUTH (TAY) *- Head of Households aged 16 to 24 only, required questions are shaded*

Question	Check One Answer	Comments
23. Are you a current or former foster care youth?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused	
24. Have you ever been in the juvenile justice system?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused	
25. Have you ever been on adult probation?	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused	
26. Which of the following best represents how you think about yourself?	☐ Straight ☐ Lesbian or Gay ☐ Bisexual ☐ Questioning ☐ Client Doesn't Know ☐ Client Refused	

VETERAN *- US Veterans only, required questions are shaded*

Question	Check One Answer	Comments
27. Which branch of the military did you serve in?	☐ Army ☐ Air Force ☐ Navy ☐ Marines ☐ Coast Guard ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
28. What type of discharge did you receive?	☐ Honorable ☐ General under honorable conditions ☐ Other than honorable conditions (OTH) ☐ Bad Conduct ☐ Dishonorable ☐ Uncharacterized ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
29. When did you enter military service?	____/____/_____ ☐ Doesn't Know	

NOTE: The following questions are required for SSVF programs, but HIGHLY recommended to be completed for all veterans.

30. When did you separate from military service?	____/____/_____ ☐ Doesn't Know	
31. What is the AMI percentage for the Household's Income?	☐ Less than 30% ☐ 30% to 50% ☐ Greater than 50%	
32. HP Screening Score *(Homelessness Prevention Only)*	_____	
33. VAMC Station Number	_____	

Did you serve in any of the following wars/war eras?

34. World War II *Dec. 1941 – Dec. 1946*	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
35. Korean War *Jun. 1950 – Jan. 1955*	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	
36. Vietnam War *Feb. 1961 – May 1975*	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected	

37. Persian Gulf War (Operation Desert Storm) *Aug. 1990 – April 1991*	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected
38. Afghanistan (Operation Enduring Freedom) *Oct. 2001 - Present*	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected
39. Iraq (Operation Iraqi Freedom) *Mar. 2003 – Aug. 2010*	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected
40. Iraq (Operation New Dawn) *Sept. 2010 – Dec. 2011*	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected
41. Other Peace-keeping Operations or Military Interventions (such as Lebanon, Panama, Somalia, Bosnia, Kosovo)	☐ No ☐ Yes	☐ Client Doesn't Know ☐ Client Refused ☐ Data not Collected

CHRONIC HOMELESSNESS *- Adults aged 18 and older and Head of Household < 18 years old, required questions are shaded*

Question	Check One Answer	Comments
ASSESSOR ONLY – DO NOT ASK: **42.** Is the respondent chronically homeless? *To be chronically homeless, the client must be an unaccompanied homeless individual with a disabling condition or a family with at least one adult member who has a disabling condition who has either been continuously homeless* for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years. To be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency shelter during that time.*	☐ No ☐ Yes	

Client Signature _____ Site _____ Date _____

Agency Staff Signature _____ Site _____ Date _____