NorCal HMIS FEMA/COVID 19 Intake Form – Adult

1. Intake Summary

Agency Case No:		**Service Point Client No:**
Intake Date	Month Day Year	Intake Staff Name
Case Manager		Staff Direct Phone Line
Agency Name		Notice of Privacy Practices Acknowledgement signed ☐ Yes ☐ No
Program Name		Release of Information (ROI) Signed ☐ Yes ☐ No

2. Household Information

Household Type	☐ Couple (parent & friend) & child(ren)	☐ Foster Parent(s) with child(ren)	☐ Other
	☐ Couple with no child(ren)	☐ Grandparent(s) with child(ren)	☐ Single Adult
	☐ Extended family unit	☐ Male Single Parent	☐ Two Parents with child(ren)
	☐ Female Single Parent	☐ Non-custodial Caregiver(s) w/child(ren)	

3. Client Information

First	Middle	Last	Suffix

Alias	Email Address

Last or Current Address		Telephone

SSN	- -	**U.S. Military Veteran** *(adults only)*	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
SSN Data Quality	☐ Full Reported ☐ Partial/Approx. Reported ☐ Client doesn't know ☐ Client refused		
Date of Birth	Month Day Year	**Gender**	☐ Male ☐ Female ☐ Transgender male to female ☐ Transgender female to male ☐ Gender Non-conforming ☐ Client doesn't know ☐ Client refused
DOB Data Quality	☐ Full Reported ☐ Partial/Approx. Reported ☐ Client doesn't know ☐ Client refused		
Primary Race & Secondary Race	Pri Sec ☐ ☐ American Indian or Alaska Native ☐ ☐ Asian ☐ ☐ Black or African-American ☐ ☐ Native Hawaiian or Pacific Islander ☐ ☐ White ☐ ☐ Client doesn't know ☐ ☐ Client refused	**Ethnicity**	☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Client doesn't know ☐ Client refused
Relationship to Head of Household (HoH)	☐ Self (Head of Household) ☐ Head of Household's child ☐ Head of Household's spouse or partner ☐ Head of Household's other relation member ☐ Other (non-relation member)	**Disabling Condition?**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Zip Code of Last Permanent Address		**Client Location (CoC) & Current County of Service**	☐ CA-516 ☐ Del Norte ☐ Lassen ☐ Modoc ☐ Plumas ☐ Shasta ☐ Sierra ☐ Siskiyou
Zip Data Quality	☐ Full Reported ☐ Partial/Approx. Reported ☐ Client doesn't know ☐ Client refused		

NOTES:

4. Homeless Determination

NorCal HMIS FEMA/COVID 19 Intake Form – Adult

Prior Living Situation **Where did you spend last night?** *(all adults & unaccompanied youth)*	**--HOMELESS SITUATION--** ☐ Place not meant for human habitation (car, abandoned building, bus or train station, etc.) ☐ Emergency shelter (incl. hotel/motel or campground paid for w/ES voucher, or RHY-funded Host Home Shelter) (ES) ☐ Safe Haven (SH) **--INSTITUTIONAL SITUATIONS--** ☐ 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/detox **--TEMPORARY AND PERMANENT HOUSING SITUATIONS** ☐ Residential project or halfway house w/no homeless criteria ☐ Hotel or motel paid for without emergency shelter voucher ☐ Transitional housing for homeless persons (including homeless youth)* ☐ 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 ☐ Rental by client, with GPD TIP housing subsidy ☐ Rental by client, with VASH 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 ☐ Data Not Collected	*If yes to Transitional/Permanent Housing: On the night before, did you stay on the streets, ES or SH? ☐ Yes ☐ No	
Length of stay in previous place	☐ 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 refused	**Number of times client has been homeless (on the streets, in ES, or SH) in past three years including today**	☐ 1 time ☐ 2 times ☐ 3 times ☐ Four or more times ☐ Client doesn't know ☐ Client refused
Approximate date homelessness started	Month Day Year	**Total number of months homeless on the street in the past three years**	☐ 1 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

5. Monthly Income

Income from any source: ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

Source of Income:	Receiving Income Source	Amount Received	Additional Household Members	Notes
Alimony or Other Spousal Support	☐ Yes ☐ No	$	$	
Child Support	☐ Yes ☐ No	$	$	
Earned Income (wages)	☐ Yes ☐ No	$	$	
General Assistance (GA)	☐ Yes ☐ No	$	$	
Other	☐ Yes ☐ No	$	$	
Pension or retirement income from another job	☐ Yes ☐ No	$	$	
Private Disability Insurance	☐ Yes ☐ No	$	$	
Retirement Income from Social Security	☐ Yes ☐ No	$	$	
SSDI	☐ Yes ☐ No	$	$	
SSI	☐ Yes ☐ No	$	$	
TANF (including CalWORKs)	☐ Yes ☐ No	$	$	
Unemployment Insurance	☐ Yes ☐ No	$	$	
VA Non-Service Connected Disability Pension	☐ Yes ☐ No	$	$	

VA Service Connected Disability Compensation	☐ Yes ☐ No	$	$	
Worker's Compensation	☐ Yes ☐ No	$	$	

6. Non-Cash Benefits

Non-cash benefit from any source: ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

Source of Non-cash benefit:	Receiving Benefit	Type Received	Additional Household Members	Notes
SNAP including CalFresh (Food Stamps)	☐ Yes ☐ No			
Special Supplemental Nutrition Program (WIC)	☐ Yes ☐ No			
TANF Child Care Services	☐ Yes ☐ No			
TANF Transportation Services	☐ Yes ☐ No			
Other TANF Funded Services (Sec.8/Public Housing/Rent Assist)	☐ Yes ☐ No			
Other Source	☐ Yes ☐ No			

7. Health Insurance

Covered by Health Insurance: ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

Health Insurance type:	Covered?	Start date	Insurance Notes
MEDICAID/MEDI-CAL	☐ Yes ☐ No		
MEDICARE	☐ Yes ☐ No		
State Children's Health Insurance Program	☐ Yes ☐ No		
Veteran's Administration (VA) Medical Services	☐ Yes ☐ No		
Employer – Provided Health Insurance	☐ Yes ☐ No		
Health Insurance obtained through COBRA	☐ Yes ☐ No		
Private Pay Health Insurance	☐ Yes ☐ No		
State Health Insurance for Adults	☐ Yes ☐ No		
Indian Health Services Program	☐ Yes ☐ No		
Other	☐ Yes ☐ No		

8. Disabilities

Disability Type:	Disability Determination	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	Start date	Disability Notes
Alcohol Abuse	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ Client doesn't know ☐ No ☐ Client refused		
Both Alcohol and Drug Abuse	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ Client doesn't know ☐ No ☐ Client refused		
Chronic Health Condition	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ Client doesn't know ☐ No ☐ Client refused		
Developmental	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ Client doesn't know ☐ No ☐ Client refused		
Drug Abuse	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ Client doesn't know ☐ No ☐ Client refused		
HIV/AIDS	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ Client doesn't know ☐ No ☐ Client refused		
Mental Health Problem	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ Client doesn't know ☐ No ☐ Client refused		

NorCal HMIS FEMA/COVID 19 Intake Form – Adult

Physical	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ Client doesn't know ☐ No ☐ Client refused		

9. Domestic Violence Questions

Are you a Domestic Violence Victim/Survivor?	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
IF YES – When did the Domestic Violence experience occur?	☐ Within past 3 months ☐ 3-6 mo. Ago ☐ 6-12 mo. Ago ☐ More than a year ago ☐ Client doesn't know ☐ Client refused
	IF YES – Are you currently fleeing? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

10. Coordinated Entry Questions

Case Conferencing Requested: ☐ Yes ☐ No

Do you have a felony conviction?	☐ Yes ☐ No	**Registered sex offender?**	☐ Yes ☐ No
Have you ever been denied housing because of criminal convictions?	☐ Yes ☐ No	**Do you have any pets?**	☐ Yes ☐ No

Desired County Destination: **Shasta** **Plumas** **Sierra** **Lassen** **Modoc** **Siskiyou** **Del Norte**
(Circle One)

Problem Solving/Diversion (optional):

Do you have a place to sleep tonight?

Are you currently in danger?

What is your most urgent need today?

11. Residential Move-In Date *(RRH Only)*

If Yes, Date of Move-In	Month	Day	Year

12. Street Outreach Only

Date of Engagement:

13. FEMA (NCS) COVID 19 –This section is to be completed if a client is sheltered by FEMA

Additional Information for *Head of Household*

Head of Household Cell Phone Number:	☐ Full Reported ☐ Partial/Approx. Reported ☐ Client doesn't know ☐ Client refused	Head of Household email address:	☐ Full Reported ☐ Partial/Approx. Reported ☐ Client doesn't know ☐ Client refused

COVID-19 Screening Results for qualifying Household member:
☐ Asymptomatic Low Risk
☐ Asymptomatic High Risk (65+ or underlying medical condition)
☐ COVID-19 Exposed (as documented by a healthcare professional)
☐ COVID-19 Positive

Total Number of Adults in Household (Numbers should reflect the total number of adults in the household who will need to be permanently housed at exit from the NCS project)	☐ 0 ☐ 6 ☐ 1 ☐ 7 ☐ 2 ☐ 8 ☐ 3 ☐ 9 ☐ 4 ☐ 10 ☐ 5	Total Number of Children in Household (Numbers should reflect the total number of children in the household who will need to be permanently housed at exit from the NCS project)	☐ 0 ☐ 7 ☐ 1 ☐ 2 ☐ 8 ☐ 3 ☐ 4 ☐ 9 ☐ 5 ☐ 6 ☐ 10

Pets in the Household ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused ☐ Data not collected	Service Animal In the Household ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused ☐ Data not collected	Access/functional needs identified ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused ☐ Data not collected

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Shaded Area To Be Filled Out by FEMA Shelter

Shelter Type (FEMA Shelter)
- ☐ Hotel/Motel
- ☐ Shelter
- ☐ Apartment
- ☐ Trailer

Name of Shelter (FEMA Shelter)	Address:
	City: Zip:

14. COVID-19 Assessment

Date Entered Into Social Isolation		**Note on Exposure**	

Symptomatic

Fever	☐ Yes ☐ No
Cough	☐ Yes ☐ No
Shortness of Breath	☐ Yes ☐ No

Test Results:

Positive Results Information

Medical Facility	
Quarantine Start Date:	
Quarantine End Date:	
Case Worker Name and Contact:	

Last Update 04/12/2021