

HMIS Data Collection Template for Project ENTRY – CoC Program

This form can be used by all CoC-funded project types: Prevention, Street Outreach, Safe Haven, Transitional Housing, Rapid Re-housing, Permanent Supportive Housing, and Services Only. Some project types are also required to track other information such as contacts, engagement, or move-in date. See [supplemental forms](#) for Prevention, Rapid Re-housing, and Street Outreach projects.

FOR TEXT FIELDS, USE BLOCK LETTERS. OTHERWISE, MARK APPROPRIATE BOXES WITH AN “X”

The form is broken into two sections for *All Clients*, and *Head of Household and Other Adults in the Household* in order to eliminate duplication of data gathering when characteristics apply to certain members of households.

DATA FOR ALL CLIENTS

Respond to the following questions for all household members—each adult and child. A separate form should be included for each household member.

PROJECT ENTRY DATE (e.g., 08/24/2014)

The Project Entry Date will serve as the information date for all data elements collected on this form; all data must be accurate as of this date, regardless of the date collected.

		/			/				
Month			Day			Year			

NAME (first, middle, last name, suffix (e.g., Jr, Sr, III))

First name																	
Middle name																	
Last name																	
Suffix																	

NAME DATA QUALITY

Full name reported

Partial, street name, or code name reported

Client doesn't know

Client refused

SOCIAL SECURITY NUMBER

			-			-				
--	--	--	---	--	--	---	--	--	--	--

DATE OF BIRTH (e.g., 10/23/1978)

		/			/				
Month			Day			Year			

SOCIAL SECURITY NUMBER DATA QUALITY

Full SSN reported

Approximate or partial SSN reported

Client doesn't know

Client refused

DATE OF BIRTH TYPE

Full date of birth reported

Approximate or partial date of birth reported

Client doesn't know

Client refused

DATA FOR ALL CLIENTS (CONTINUED)

RELATIONSHIP TO HEAD OF HOUSEHOLD

- | | |
|--|--|
| <input type="checkbox"/> Self (head of household) | <input type="checkbox"/> Head of household's other relation member (other relation to head of household) |
| <input type="checkbox"/> Head of household's child | <input type="checkbox"/> Other: non-relation member |
| <input type="checkbox"/> Head of household's spouse or partner | |

RACE

More than one race is permitted. *Client doesn't know* and *Client refused* should only be selected if no other response is selected. If the client wishes to indicate "Hispanic or Latino," please indicate that in the next question (Ethnicity) and then select the appropriate race category here.

- | | |
|--|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> White |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Client refused |
| <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | |

ETHNICITY

- | | |
|--|--|
| <input type="checkbox"/> Non-Hispanic / Non-Latino | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Hispanic / Latino | <input type="checkbox"/> Client refused |

GENDER

- | | |
|---|--|
| <input type="checkbox"/> Female | <input type="checkbox"/> Doesn't identify as male, female or transgender |
| <input type="checkbox"/> Male | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Transgender male to female | <input type="checkbox"/> Client refused |
| <input type="checkbox"/> Transgender female to male | |

DATA FOR ALL CLIENTS (CONTINUED)

HEALTH INSURANCE

Is the client currently covered by health insurance?

No

Yes

Client doesn't know

Client refused



[IF YES] Answer 'Yes' or 'No' for each health insurance source.

Answer 'No' for sources that have been terminated, even if they were received in the past.

No	Yes	Source of non-cash benefit
<input type="checkbox"/>	<input type="checkbox"/>	Medicaid
<input type="checkbox"/>	<input type="checkbox"/>	Medicare
<input type="checkbox"/>	<input type="checkbox"/>	State Children's Health Insurance Program (or use local name)
<input type="checkbox"/>	<input type="checkbox"/>	Veteran's Administration (VA) Medical Services
<input type="checkbox"/>	<input type="checkbox"/>	Employer-Provided Health Insurance
<input type="checkbox"/>	<input type="checkbox"/>	Health insurance obtained through COBRA
<input type="checkbox"/>	<input type="checkbox"/>	Private Pay Health Insurance
<input type="checkbox"/>	<input type="checkbox"/>	State Health Insurance for Adults (or use local name)
<input type="checkbox"/>	<input type="checkbox"/>	Indian Health Services Program
<input type="checkbox"/>	<input type="checkbox"/>	Other If Yes, specify source: _____

PHYSICAL DISABILITY

Does the client currently have a physical disability?

No

Yes

Client doesn't know

Client refused



[IF YES for physical disability] Is the physical disability expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

No

Yes

Client doesn't know

Client refused

[IF YES for physical disability] Is documentation of the disability and severity on file?

No

Yes

[IF YES for physical disability] Is the client currently receiving services/treatment for this disability?

No

Yes

Client doesn't know

Client refused

DATA FOR ALL CLIENTS (CONTINUED)

DEVELOPMENTAL DISABILITY

Does the client currently have a developmental disability?

No

Yes

Client doesn't know

Client refused



[IF YES for developmental disability] Is the developmental disability expected to substantially impair the client's ability to live independently?

No

Yes

Client doesn't know

Client refused

[IF YES for developmental disability] Is documentation of the disability and severity on file?

No

Yes

[IF YES for developmental disability] Is the client currently receiving services/treatment for this disability?

No

Yes

Client doesn't know

Client refused

CHRONIC HEALTH CONDITION

Does the client currently have a chronic health condition?

No

Yes

Client doesn't know

Client refused



[IF YES for chronic health condition] Is the chronic health condition expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

No

Yes

Client doesn't know

Client refused

[IF YES for chronic health condition] Is documentation of the disability and severity on file?

No

Yes

[IF YES for chronic health condition] Is the client currently receiving services/treatment for this condition?

No

Yes

Client doesn't know

Client refused

DATA FOR ALL CLIENTS (CONTINUED)

HIV/AIDS

Does the client currently have HIV/AIDS?

No

Yes

Client doesn't know

Client refused



[IF YES for HIV/AIDS] Is HIV/AIDS expected to substantially impair the client's ability to live independently?

No

Yes

Client doesn't know

Client refused

[IF YES for HIV/AIDS] Is documentation of the disability and severity on file?

No

Yes

[IF YES for HIV/AIDS] Is the client currently receiving services/treatment for this condition?

No

Yes

Client doesn't know

Client refused

MENTAL HEALTH PROBLEM

Does the client currently have a mental health problem?

No

Yes

Client doesn't know

Client refused



[IF YES for mental health problem] Is the mental health problem expected to be of long-continued and indefinite duration and substantially impairs the client's ability to live independently?

No

Yes

Client doesn't know

Client refused

[IF YES for mental health problem] Is documentation of the disability and severity on file?

No

Yes

[IF YES for mental health problem] Is the client currently receiving services/treatment for this condition?

No

Yes

Client doesn't know

Client refused

DATA FOR ALL CLIENTS (CONTINUED)

SUBSTANCE ABUSE PROBLEM

Does the client currently have a substance abuse problem?

- | | |
|---|---|
| <input type="checkbox"/> No | <input type="checkbox"/> Both alcohol and drug abuse |
| <input checked="" type="checkbox"/> Alcohol abuse | <input checked="" type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Client refused |



[IF YES for alcohol abuse, drug abuse, or both alcohol and drug abuse for substance abuse problem] Is the substance abuse problem expected to be of long-continued and indefinite duration and substantially impairs client's ability to live independently?

- | | |
|---|--|
| <input type="checkbox"/> No | <input type="checkbox"/> Client doesn't know |
| <input checked="" type="checkbox"/> Yes | <input checked="" type="checkbox"/> Client refused |

[IF YES for alcohol abuse, drug abuse, or both alcohol and drug abuse for substance abuse problem] Is documentation of the disability and severity on file?

- | |
|---|
| <input type="checkbox"/> No |
| <input checked="" type="checkbox"/> Yes |

[IF YES for alcohol abuse, drug abuse, or both alcohol and drug abuse for substance abuse problem] Is client currently receiving services/treatment for this condition?

- | | |
|---|--|
| <input type="checkbox"/> No | <input type="checkbox"/> Client doesn't know |
| <input checked="" type="checkbox"/> Yes | <input checked="" type="checkbox"/> Client refused |

DISABLING CONDITION

A disabling condition is any of the above-indicated disabilities (physical disability, developmental disability, chronic health condition, HIV/AIDS, mental health problem, or substance abuse problem) or any other physical, mental, or emotional impairment (including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury) that is expected to be of long-continued and indefinite duration and substantially impairs ability to live independently.

Does the client currently have a disabling condition?

- | |
|--|
| <input type="checkbox"/> No |
| <input checked="" type="checkbox"/> Yes |
| <input type="checkbox"/> Client doesn't know |
| <input checked="" type="checkbox"/> Client refused |

DATA FOR HEAD OF HOUSEHOLD AND OTHER ADULTS

Respond to the following questions for any adult in the household. If the household is composed of an unaccompanied child, that child is the head of household. If the household is composed of two or more minors, data must be collected about the minor that has been designated as the head of household. A separate form should be included for each adult member of the household.

HOUSING STATUS

Housing status is *only* required to be collected by CoC Program-funded projects in those CoCs that are approved by HUD to serve clients who meet the definition of Homeless under Category 3 (homeless under other federal statutes). CoCs without the approval to serve clients who are homeless under Category 3 may still opt to have projects collect the Housing Status data element, but are not required to do so by HUD.

- | | |
|--|---|
| <input type="checkbox"/> Category 1 – Homeless | <input type="checkbox"/> At-risk of homelessness* |
| <input type="checkbox"/> Category 2 – At imminent risk of losing housing | <input type="checkbox"/> Stably housed |
| <input type="checkbox"/> Category 3 – Homeless only under other federal statutes | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Category 4 – Fleeing domestic violence | <input type="checkbox"/> Client refused |

**At project entry, the category of At-risk of homelessness is only a valid response for clients being served by Homelessness Prevention or Coordinated Assessment projects.*

LIVING SITUATION PRIOR TO PROJECT ENTRY

Separate, [supplemental forms are provided](#) to complete this data element. Note that Street Outreach, Emergency Shelter, and Safe Haven projects have a separate form from all other project types.

Projects may modify this form to paste in the content from the appropriate supplemental form for their project type.

VETERAN STATUS

Veteran Status is only collected on heads of household who are 18 years of age and older, as well as all other adults in the household. A veteran is anyone who has ever been on active duty in the armed forces of the United States, regardless of discharge status or length of service. For the Army, Navy, Air Force, Marine Corps, and Coast Guard, active duty begins when a military member reports to a duty station after completion of training. For the Reserves and National Guard, active duty is any time spent activated or deployed, either in the United States or abroad.

Is the client a veteran?

- | |
|--|
| <input type="checkbox"/> No |
| <input type="checkbox"/> Yes |
| <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Client refused |

DATA FOR HEAD OF HOUSEHOLD AND OTHER ADULTS (CONTINUED)

DOMESTIC VIOLENCE

Is client a domestic violence victim/survivor?

No

Yes

Client doesn't know

Client refused



[IF YES] When did the experience occur?

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 refused

[IF YES] Is the client currently fleeing?

No

Yes

Client doesn't know

Client refused

DATA FOR HEAD OF HOUSEHOLD AND OTHER ADULTS (CONTINUED)

INCOME AND SOURCES

Only record regular, recurrent sources that are current as of today (i.e. not terminated). Income received for a minor member of the household (e.g. SSI) should be recorded under the Head of Household's information (income from employment of a minor can be excluded from the household income).

Does the client have any income from any source?

No

Yes

Client doesn't know

Client refused



[IF YES] Answer Yes or No for each income source. If the response for a source is 'Yes', enter the monthly amount received based on current income. If unsure of the exact monthly amount, enter client's best estimate.

Source of income	Receiving income from source?	If yes, monthly amount from source (round to nearest dollar)			
Earned income (i.e., employment income)	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
Unemployment Insurance	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
Supplemental Security Income (SSI)	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
Social Security Disability Income (SSDI)	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
VA Service-Connected Disability Compensation	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
VA Non-Service-Connected Disability Pension	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
Private disability insurance	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
Worker's Compensation	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
Temporary Assistance for Needy Families (TANF)	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
General Assistance (GA)	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
Retirement Income from Social Security	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
Pension or retirement income from a former job	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
Child support	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
Alimony or other spousal support	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
Other source If yes, specify source: _____	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
Total monthly income from all sources			\$. 0 0

DATA FOR HEAD OF HOUSEHOLD AND OTHER ADULTS (CONTINUED)

NON-CASH BENEFITS

Only record regular, recurrent sources that are current as of today (not terminated). If a non-cash benefit is only received by a minor member of the household, record under the Head of Household's information.

Does the client have any non-cash benefits from any source?

No

Client doesn't know

Yes

Client refused



[IF YES] Answer 'Yes' or 'No' for each non-cash benefit source. (Answer 'No' for benefits that have been terminated, even if they were received in the past.)

No	Yes	Source of non-cash benefit
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Nutrition Assistance Program (SNAP)
<input type="checkbox"/>	<input type="checkbox"/>	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
<input type="checkbox"/>	<input type="checkbox"/>	TANF Child Care services <i>(or use local name)</i>
<input type="checkbox"/>	<input type="checkbox"/>	TANF transportation services <i>(or use local name)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Other TANF-Funded Services <i>(or use local name)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Section 8, Public Housing, or other ongoing rental assistance
<input type="checkbox"/>	<input type="checkbox"/>	Temporary rental assistance
<input type="checkbox"/>	<input type="checkbox"/>	Other source: _____