|  |
| --- |
| **MCI ID:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **HMIS ID:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Staff Initials/Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Grant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Program Enrollment Date: \_\_\_\_\_\_\_\_\_\_\_\_\_** |

**HMIS ADULT/CHILD ENTRY FORM**

***\*\*Any data that cannot be collected, please write in Data Not Collected\*\****

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Name*** |  | ***Anniversary Date*** |  | ***Assessment/Information Date*** |
|  |  |  |  |  |

\*Check all demographic information on the household screen in HMIS to ensure it is all filled in and there is no client refused, client doesn’t know, data not collected\*

*Additional Household Members (please fill out a form or each additional household member mentioned below)*

|  |  |
| --- | --- |
| **Name** | **Relationship to HOH**  **(child, spouse, other relation member, other non-relation member, HoH)** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

*Housing Disposition*

|  |  |
| --- | --- |
| **Residential Move-in Date** | **Address** |
|  |  |
| **Moving On Assistance Date** | **Moving On Assistance Provided (select all that apply)** |
|  | Subsidized housing application assistance  Financial assistance for Moving On (e.g. security deposit, moving expenses)  Non-financial assistance for Moving On (e.g. housing navigation, transition support)  Housing referral/placement  Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

*Domestic Violence*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Victim/Survivor | When did this happen? | | | |
| Yes  No | Within the past 3 months | Within the past 3-6 months | Within the past 6-12 months | More than 1 year ago |

*Employment (for anyone 18+)*

|  |  |
| --- | --- |
| Yes | No |
| Full-Time | Looking for Work |
| Part-time | Not Looking for Work |
| Seasonal | Unable to Work |

*Income (for anyone 18+)*

YES If Yes, complete table below.  NO If No, skip to the next table.

|  |  |  |  |
| --- | --- | --- | --- |
| Source | If yes, Amount - *monthly* | Source | If yes, Amount - *monthly* |
| Earned Income (Employment) | $ | VA Service-Connected Disability Compensation | $ |
| Unemployment Insurance | $ | VA Non-svc Connected Disability Pension | $ |
| GA | $ | Private Disability Insurance | $ |
| Retirement Income from Social Security | $ | Cash Assistance/TANF | $ |
| Worker’s Compensation | $ | Alimony or Other Spousal Support | $ |
| SSI | $ | Child Support | $ |
| SSDI | $ | UTA | $ |
|  |  | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | $ |

|  |  |  |  |
| --- | --- | --- | --- |
| ***Connection to SOAR*** | Yes  No | ***Total Monthly Income*** | $ |

*Non-cash Benefits (for anyone 18+)*

**YES** If Yes, complete table below.

**NO** If No, skip to the next table.

|  |
| --- |
| Source (select all that apply) |
| SNAP (Food Stamps)  WIC  TANF Childcare Services  TANF Transportation Services  Other TANF-funded Services  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

*Health Insurance (for all clients)*

**YES** If Yes, complete table below.   
 **NO** If No, skip to the next table.

|  |  |
| --- | --- |
| Source (select all that apply) | |
| Medicaid  Medicare  State Children’s Health Insurance Program (CHIP)  VA medical services  Employer Provided health insurance | Health insurance obtained through COBRA  Private Pay Health Insurance  State Health Insurance for Adults  Indian Health Services Program |

***Education***

|  |  |  |  |
| --- | --- | --- | --- |
| **Adults and Children 6+** | | | |
| **Last Grade Completed** | | **School Status** | |
| Less than 5 | 5-6 | Graduated from high school | Completed |
| 7-8 | 9-11 | Obtained GED | Not of school age |
| 12/High School Diploma | School program doesn’t have grade levels | Attending Regularly | Attending irregularly |
| GED | Some college | Suspended | Dropped out |
| Associates/Bachelors/Grad | Vocational certificate | Expelled |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Age 0-5 | | | | |
| Has the child received a developmental screening? | Yes | | No | |
| **IF NO,** has the child been referred to an agency for a developmental screening? | Yes | | No | |
| **IF NO,** was/will a developmental screening be completed during program enrollment? | Yes | | No | |
| Is the family intending to send the child to an early learning program? | Early Head Start  Head Start | Other preschool program  No | | Other childcare program |
| Is the child enrolled? | Yes  On waiting list | | No | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Age 6+ | | | | |
| Enrollment status | District of residence | Not Enrolled | | District of region |
| **If not enrolled, Why?** | Communication needed between former and intended school  Transportation issues | | Issued General Employment Certification  Other – *please specify* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Name of district |  | | | |
| Name of school |  | | | |

*Physical and Mental Health*

|  |  |  |  |
| --- | --- | --- | --- |
| Disabling Conditions | Yes No |  |  |
| Dental Health Status | Excellent  Very Good  Good  Fair  Poor | Mental Health Status | Excellent  Very Good  Good  Fair  Poor |
| Type | **Expected to be long-term?** | Type | Expected to be long-term? |
| Physical | Yes No | HIV/AIDS | |
| Developmental | |  |  |
| Chronic health condition | Yes No |  |  |
| Mental health disorder | Yes No | Alcohol use disorder | Yes No |
| Drug use disorder | Yes No | Alcohol and drug use disorder | Yes No |

*Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Staff Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*