**NEBRASKA INTAKE: RHY**

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| **DATE OF DATA COLLECTION** |
|   |  | **/** |  |  | **/** |  |  |  |  |

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| **HMIS CLIENT ID - For HMIS Users only** |
|  |  |  |  |  |  |  |  |  |

Month Day Year

|  |  |
| --- | --- |
| **SOCIAL SECURITY NUMBER** | **SSN Data Quality** |
|  |  | Full Reported |  | Approximate or Partial Reported |  | Client doesn’t know |  | Client refused |  | Data not collected |

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| **NAME - (First, Middle, Last, Suffix)** |
| Last Name |  |
| First Name |  |
| Middle Name |  |
| Suffix (Jr, III) |  |
| Alias/Maiden |  |

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| **Name Data Quality** |
|  | Full name reported |
|  | Partial, street name or code name |
|  | Client doesn’t know (CDK) |
|  | Client refused (CR) |
|  | Data Not Collected (DNC) |

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| **DATE OF BIRTH****(e.g. 10/23/1978)** | **DOB Data Quality** |
|  |  | Full Reported |  | Approximate or Partial Reported |  | Client doesn’t know |  | Client refused |  | Data not collected |

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| **GENDER (select all applicable)** |
|  | Female |  | Questioning |
|  | Male |  | Client doesn’t know |
|  | A gender that is not singularly ‘Female’ or ‘Male’ |  | Client refused |
|  | Transgender |  | Data not collected |

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| **RACE (select all applicable)** |
|  | American Indian, Alaska Native, or Indigenous |  | White |
|  | Asian or Asian American |  | Client doesn’t know |
|  | Black, African American, or African |  | Client refused |
|  | Native Hawaiian or Pacific Islander |  | Data not collected |

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| **ETHNICITY** |
|  | Non-Hispanic / Non-Latin(a)(o)(x) |  | Client doesn’t know |
|  | Hispanic / Latin(a)(o)(x) |  | Client refused |
|   |  | Data not collected |

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| **VETERAN STATUS** |
|  | Yes |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |

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| **ZIP CODE OF LAST PERMANENT ADDRESS:** |  |

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| **RHY BCP STATUS – Complete RHY-BCP status determination only once, when the status determination has occurred. There should only be one RHY-BCP status determination per project stay.**  |
| Date RHY-BCP Status Determined: **\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_** |
| Youth Eligible for RHY Services: |  | Yes |  | No |

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| --- | --- | --- | --- | --- |
| **Is your need for assistance due to COVID-19?** |  | Yes |  | No |

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| **RELATIONSHIP TO HEAD OF HOUSEHOLD** |
|  | Self (head of household) |  | Other relation to head of household |
|  | Head of household’s child |  | Other: non-relation member |
|  | Head of household’s spouse or partner |  | Data not collected |

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| **HOUSING STATUS** |
|  | Category 1 - Homeless |  | At-risk of homelessness |
|  | Category 2 – At imminent risk of losing housing |  | Stably housed |
|  | Category 3 – Homeless only under other federal statutes |  | Client doesn’t know |
|  | Category 4 – Fleeing domestic violence |  | Client refused |
|  |  |  | Data not collected |

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| **PRIOR LIVING SITUATION: TYPE OF RESIDENCE – Where did the client live immediately prior to this project entry? Select one type of residence, follow the arrows and bold instructions to complete other sections.** |
| **Homeless** | **Institutional** | **Temporary & Permanent Housing** |
|  | Place not meant for habitation (e.g., a vehicle, abandoned building, bus/train station, airport or anywhere outside) |  | Foster care home or foster care group home |  | Residential or halfway house with no homeless criteria |
|  | Emergency shelter, including hotel/motel paid for withemergency shelter voucher or RHY-funded Host Home shelter |  | Hospital or other residential non- psychiatric medical facility |  | Hotel or motel paid for without emergency shelter voucher |
|  | Safe Haven |  | Jail, prison, or juvenile detention facility |  | Transitional housing for homeless persons (including homeless youth) |
|  | Client doesn’t know |  | Long-term care facility or nursing home |  | Host Home (non-crisis) |
|  | Client refused |  | Psychiatric hospital or other psychiatric facility |  | Staying or living in a friend’s room, apartment or house |
|  | Data not collected |  | Substance abuse treatment facility or detox center |  | Staying or living in a family member’s room apartment or house |
|   |   |  | Client doesn’t know |  | Rental by client, with GPD TIP subsidy |
|   |   |  | Client refused |  | Rental by client, with VASH subsidy |
|   |   |  | Data not collected |  | Permanent housing (other than RRH) for formerly homeless persons |
|   |   |  |  | Rental by client, with RRH or equivalent subsidy |
|   |   |   |  | Rental by client with HVC voucher (tenant or project based) |
|  |  |  |  | Rental by client in a public housing unit |
|   |   |   |  | Rental by client, no ongoing subsidy |
|   |   |   |  | Rental by client with other ongoing housing subsidy |
|   |   |   |  | Owned by client, with ongoing subsidy |
|   |   |   |  | Owned by client, no ongoing subsidy |
|   |   |   |  | Client doesn’t know |
|   |   |   |  | Client refused |
|   |   |   |  | Data not collected |
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| **PRIOR LIVING SITUATION: LENGTH OF STAY – How long did the client stay in that place?****For responses in the shaded boxes, follow the arrows to complete PRIOR LIVING SITUATION: BREAK IN HOMELESSNESS.** |
|  | 1 night or less |  | 1 night or less |  | 1 night or less |
|  | 2 to 6 nights |  | 2 to 6 nights |  | 2 to 6 nights |
|  | 1 week or more, but less than 1 month |  | 1 week or more, but less than 1 month |  | 1 week or more, but less than 1 month |
|  | 1 month or more, but less than 90 days |  | 1 month or more, but less than 90 days |  | 1 month or more, but less than 90 days |
|  | 90 days or more, but less than 1 year |  | 90 days or more, but less than 1 year |  | 90 days or more, but less than 1 year |
|  | 1 year or longer |  | 1 year or longer |  | 1 year or longer |
|  | Client doesn’t know |  | Client doesn’t know |  | Client doesn’t know |
|  | Client refused |  | Client refused |  | Client refused |
|  | Data not collected |  | Data not collected |  | Data not collected |
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| **PRIOR LIVING SITUATION: BREAK IN HOMELESSNESS****On the night before entering the Prior Living Situation, did the client stay on the streets or in emergency shelter?** |
| **Complete Frequency & Length** **of Homelessness Below** |  | **Yes [Complete Frequency & Length]** |  | **Yes [Complete Frequency & Length]** |
|  | No |  | No |
|  | Client doesn’t know |  | Client doesn’t know |
|  | Client refused |  | Client refused |
|  | Data not collected |  | Data not collected |

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| **PRIOR LIVING SITUATION: FREQUENCY & LENGTH OF HOMELESSNESS** |
| **Approximate Date Homelessness Started: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Number of TIMES the client been on the streets or in emergency shelter in the last 3 years including today** |
|  | One time (Select this if this is the 1st time the client has been homeless in the past 3 years) |  | Client doesn’t |
|  | Two times |  | Client refused |
|  | Three times |  | Data not collected |
|  | Four or more times |  |  |
| **Number of MONTHS, in total, the client has been homeless on the streets or in an emergency shelter** **in the last 3 years** |
|  | 1 month or less (Select this if this is the 1st time the client has been homeless in the past 3 years) |  | Client doesn’t |
|  | Between 2 and 12 Months **→** **Enter total number of months:** \_\_\_\_\_\_\_\_ |  | Client refused |
|  | More than 12 months |  | Data not collected |

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| **DISABLING CONDITION** |
|  | Yes |   |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |
| **Answer ‘Yes’ or ‘No’ for each disability type.** If the client selects ‘Yes’ for Physical, Chronic, Mental Health or any of the three Substance Use Disorders, you must also complete the shaded sections below. |
| **Disability Type** | **Yes** | **No** | **If Yes: Expected to be of long-continued and indefinite duration and** **substantially impairs client’s ability to live independently?** |
| Physical Disability |  |  |  Yes |  No |  CDK |  CR |  DNC |
| Developmental Disability  |  |  |  |  |  |  |  |
| Chronic Health Condition  |  |  |  Yes |  No |  CDK |  CR |  DNC |
| HIV/AIDS |  |  |  |  |  |  |  |
| Mental Health Disorder |  |  |  Yes |  No |  CDK |  CR |  DNC |
| Substance Use Disorder: |  |  |  |  |  |  |  |
| Alcohol use disorder |  |  |  Yes |  No |  CDK |  CR |  DNC |
| Drug use disorder |  |  |  Yes |  No |  CDK |  CR |  DNC |
| Both alcohol and drug use disorders |  |  |  Yes |  No |  CDK |  CR |  DNC |

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| **INCOME FROM ANY SOURCE – Do the head of household or any adults currently have any income from any source?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |
| **If “YES” to Income from any Source, indicate Yes or No and the amount for all sources that apply.** **To complete the table below, you must answer ‘Yes’ or ‘No’ for each income source.**Answer ‘Yes’ only if the income source is current and received as of today (i.e. not terminated).Answer ‘No’ for sources that have been terminated, even if they were received in the past.**If the response for any source is ‘Yes’, enter the monthly amount received from that source to the nearest dollar.**  |
| **Source of Income** | **Yes** | **No** | **If yes, monthly amount from source** **(round to nearest dollar)** |
| Earned Income (from job)  |  |  | $ |
| Unemployment Insurance  |  |  | $ |
| Supplemental Security Income (SSI)  |  |  | $ |
| Social Security Disability Insurance (SSDI)  |  |  | $ |
| VA Service-Connected Disability Compensation  |  |  | $ |
| VA Non-Service-Connected Disability Pension  |  |  | $ |
| Private Disability Insurance |  |  | $ |
| Worker’s Compensation  |  |  | $ |
| Temporary Assistance for Needy Families (TANF) |  |  | $ |
| General Assistance (GA)  |  |  | $ |
| Retirement income from Social Security |  |  | $ |
| Pension or retirement income from a former job  |  |  | $ |
| Child support |  |  | $ |
| Alimony and other spousal support  |  |  | $ |
| Other income source (specify): |  |  | $ |
| **Total monthly income from all sources** | $ |

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| **NON-CASH BENEFITS - Do the head of household or any adults receive non-cash benefits from any source?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |
| **To complete the table below, you must answer ‘Yes’ or ‘No’ for each source of non-cash benefit.** Answer ‘Yes’ only if the non-cash benefit is recurrent and received as of today (i.e. not terminated). Answer ‘No’ for non-cash benefits that have been terminated, even if they were received in the past.**If the response for any non-cash benefit is ‘Yes’, complete the shaded section.** |
| **Source of Non-Cash Benefit** | **Yes** | **No** | **If yes, monthly amount from source****(round to nearest dollar)** |
| Supplemental Nutrition Assistance Program (SNAP) |  |  | $ |
| Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) |  |  | $ |
| TANF Child Care Services  |  |  | $ |
| TANF Transportation Services  |  |  | $ |
| Other TANF-funded Services  |  |  | $ |
| Other Non-Cash Benefit (specify): |  |  | $ |

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| **HEALTH INSURANCE - Is the client currently covered by health insurance?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |
| **If YES to Health Insurance, check all coverage that applies:** |
|  | Medicaid |  | Health Insurance obtained through COBRA  |
|  | Medicare |  | Private Pay Health Insurance  |
|  | State Children’s Health Insurance Program (SCHIP) |  | State Health Insurance for Adults |
|  | Veteran’s Administration (VA) Medical Services  |  | Indian Health Services Program |
|  | Employer-Provided Health Insurance  |  | Other (specify): |

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| **SEXUAL ORIENTATION** |
|  | Heterosexual |  | Other: |
|  | Gay |  | Client doesn’t know |
|  | Lesbian |  | Client refused |
|  | Bisexual |  | Data not collected |
|  | Questioning / Unsure |  |  |

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| **LAST GRADE COMPLETED** |
|  | Less than Grade 5 |  | School program does not have grade levels |  | Graduate degree |
|  | Grades 5-6 |  | GED |  | Vocational certification |
|  | Grades 7-8 |  | Some college |  | Client doesn’t know |
|  | Grades 9-11 |  | Associates degree |  | Client refused |
|  | Grade 12 |  | Bachelor’s degree |  | Data not collected |

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| **SCHOOL STATUS** |
|  | Attending school regularly |  | Suspended |
|  | Attending school irregularly |  | Expelled |
|  | Graduated from high school |  | Client doesn’t know |
|  | Obtained GED |  | Client refused |
|  | Dropped out |  | Data not collected |

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| **EMPLOYED?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |
| **IF YES, what type of employment?** |
|  | Full-Time |  | Part-Time |  | Seasonal/Sporadic (including day labor) |  | Data not collected |
| **IF NO, why is the client not employed?** |
|  | Looking for work |  | Unable to work |  | Not looking for work |  | Data not collected |

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| **GENERAL HEALTH STATUS** |
|  | Excellent |  | Poor |
|  | Very Good |  | Client doesn’t know |
|  | Good |  | Client refused |
|  | Fair |  | Data not collected |

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| **DENTAL HEALTH STATUS** |
|  | Excellent |  | Poor |
|  | Very Good |  | Client doesn’t know |
|  | Good |  | Client refused |
|  | Fair |  | Data not collected |

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| **MENTAL HEALTH STATUS** |
|  | Excellent |  | Poor |
|  | Very Good |  | Client doesn’t know |
|  | Good |  | Client refused |
|  | Fair |  | Data not collected |

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| **PREGNANCY STATUS** |
|  | Yes |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |
| **IF YES, projected due date?** |  |  | **/** |  |  | **/** |  |  |  |  |
|  | Month |  | Day |  | Year |

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| **FORMERLY A WARD OF CHILD WELFARE OR FOSTER CARE AGENCY** |
|  | Yes |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |
| **If YES, number of years** |
|  | Less than one year 🡪 Enter number of months \_\_\_\_\_\_\_\_ |  | 3 to 5 or more years |
|  | 1 to 2 years |  |  |

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| **FORMERLY A WARD OF THE JUVENILE JUSTICE SYSTEM** |
|  | Yes |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |
| **IF YES, number of years** |
|  | Less than one year 🡪 Enter number of months \_\_\_\_\_\_\_\_ |  | 3 to 5 or more years |
|  | 1 to 2 years |  |  |

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| **FAMILY CRITICAL ISSUES** |
| Unemployment – Family Member |  | Yes |  | No |
| Mental Health Disorder – Family Member |  | Yes |  | No |
| Physical Disability – Family Member |  | Yes |  | No |
| Alcohol or Substance Use Disorder – Family Member |  | Yes |  | No |
| Insufficient Income to Support Youth – Family Member |  | Yes |  | No |
| Incarcerated Parent of Youth |  | Yes |  | No |

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| **REFERRAL SOURCE** |
|  | Self-Referral |  | Law Enforcement / Police |
|  | Individual: Parent / Guardian / Relative / Friend / Foster Parent / Other Individual |  | Mental Hospital |
|  | Outreach Project  |  | School |
|  | Temporary Shelter |  | Other Organization |
|  | Residential Project |  | Client doesn’t know |
|  | Hotline |  | Client refused |
|  | Child Welfare/CPS |  | Data not collected |
|  | Juvenile Justice |  |  |

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| **FOSTER CARE – As a child, were you ever in Foster Care or are you now?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |

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| **VICTIM OF DOMESTIC VIOLENCE** |
|  | Yes |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |

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| **If YES, last occurrence of domestic violence** |
|  | Within the past three months |  | Client doesn’t know |
|  | Three to six months ago (excluding six months exactly) |  | Client refused |
|  | Six months to one year ago (excluding one year exactly) |  | Data not collected |
|  | One year ago or more |   |

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| **If YES, are you currently fleeing?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |

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| **CLIENT’S RESIDENCE/LAST PERMANENT ADDRESS** |
| Street Address: |
| City: | State: | ZIP Code: |
| County of Current Residence: | County of Legal Residence: |
| Home Phone #: | Cell Phone #: | Work Phone #: |



**Homeless Management Information System (HMIS)**

**Consumers Informed Consent & Release of Information Authorization**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand information about me and/or my dependents listed below is entered into a database system called Clarity Human Services. This system helps to better understand homelessness, to improve service delivery, and to evaluate the effectiveness of services provided. Participation in data collection is a critical component of our community’s ability to provide the most effective services and housing possible. The information that is collected is protected by limiting access to the database and limiting what information may be shared. Access to the data and sharing of the data is in compliance with the standards set by the federal, state, and local regulations governing confidentially of client records. Every person and agency that is authorized to read or enter information into the system has signed an agreement to maintain the security and confidentiality of the information.

By signing this form, I authorize the following:

The information collected by this agency will be included in Clarity Human Services and only partner agencies, which have entered into an HMIS Agency Participation Agreement, may use it to:

* Produce a client profile at intake that will be shared with collaborating agencies
* Produce aggregate level reports regarding use of services
* Track individual program-level outcomes
* Identify unfilled service needs and plan for enhancements
* Allocate resources among agencies engaged in services

By signing this form, I authorize the following:

I authorize the partner agencies and their representatives to share basic information regarding my family members listed below and/or me. I understand that this information is for the purpose of assessing my/our needs for housing, utility assistance, food, counseling, and/or other services.

The information may consist of the following PPI (Personal Protected Information):

|  |  |  |
| --- | --- | --- |
| * Name
 | * Family Composition
 | * Housing information
 |
| * Date of Birth
 | * Income/Non-cash
 | * Health Insurance Status
 |
| * Social Security Number
 | * Veteran Status
 | * Client Location
 |
| * Gender
 | * Domestic Violence
 | * Program Entry and Exit
 |
| * Ethnicity and Race
 | * VI-SPDAT
 | * Services Provided
 |
| * Residence Prior to Project Entry
 | * Disabling Condition
 | * Assessments
 |
| * Homeless History
 | * Photo (if applicable)
 |  |

I Understand That:

* The partner agencies have signed agreements to treat my information in a professional and confidential manner. I have the right to view the client confidentiality polices used by the HMIS partner agencies
* Staff members of the partner agencies who will see my information have signed agreements to maintain confidentiality regarding my information.
* The release of my information does not guarantee that I will receive assistance; my refusal to authorize the use of my information does not disqualify me from receiving assistance.
* My records are protected by federal, state, and local regulations governing confidentially of client records and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
* This authorization will remain in effect until I revoke it in writing, and I may revoke authorization at any time, if I revoke my authorization, all information about me already in the database will remain.
* This release is valid for one year from the date of my signature below.
* I understand I may withdraw my consent at any time.

Partner Agencies: A list of the partner agencies within the Nebraska Homeless Management Information System may be viewed prior to signing this form.

List all Dependent Children under 18 in the household, if any (first, last and DOB)

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* Auditors or funders who have legal rights to review the work of this agency, including the U.S. Department of Housing and Urban Development and Nebraska Department of Health and Human Services Homeless Assistance Program may see my complete file in HMIS if services received are funded by their Department/s.

Please initial one of the following levels of consent:

\_\_\_ I give authorization to have Protected Personal and relevant Information for me and my dependents entered into the NMIS and shared between Partner Agencies.

 Or

\_\_\_I do not consent to the inclusion of personal information in the NMIS about me and any dependents.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consumer’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Agency Staff Name (print) Agency Staff Signature Date