



COORDINATED ENTRY HMIS DATA ENTRY FORM - ADULTS

Date: \_\_\_/\_\_\_/\_\_\_\_\_

**Client Record**

Client Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Name Quality:  Full  Partial  Don't Know  Refused

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SSN Quality:  Full  Partial  Doesn't Know  Refused

U.S. Military/Veteran:  Yes  No

**Client Demographics**

Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_ DOB Type:  Full DOB Reported  Partial  Doesn't Know  Refused

**Gender:**

- Female
- Male
- A Gender Other Than Singularly Female or Male
- Transgender
- Questioning
- Doesn't Know
- Refused

**Race:**

- American Indian, Alaskan Native, or Indigenous
- Asian or Asian American
- Black, African American, or African
- Native Hawaiian or Pacific Islander
- White
- Doesn't Know
- Refused

Ethnicity:  Hispanic/Latino  Non-Hispanic/Latino  Doesn't Know  Refused

**Relationship to Head of Household:**

- Self
- Child
- Spouse
- Partner
- Other Relation
- Other: Non-relation

Client Location: VT-501 Burlington/Chittenden County CoC

**Client Contact Information**

Current Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_



## Prior Living Situation

**\*\*If client is not becoming homeless following having long-term stable housing, please fill out Mapping Housing History on page 3 in addition to this page. The client's answers in Mapping Housing History will help to inform the answers to the questions on the bottom of this page.\*\***

### Type of Residence:

<input type="checkbox"/> Place not meant for habitation	<input type="checkbox"/> Staying or living in a family member's room, apartment or house
<input type="checkbox"/> Emergency Shelter including Hotel with voucher	<input type="checkbox"/> Rental by client, with GPD TIP housing subsidy
<input type="checkbox"/> Safe Haven	<input type="checkbox"/> Rental by client, with VASH housing subsidy
<input type="checkbox"/> Foster care home or foster care group home	<input type="checkbox"/> Permanent housing (non-RRH) for formerly homeless persons (such as SHP, S+C, or SRO)
<input type="checkbox"/> Hospital/medical facility (non-psychiatric)	<input type="checkbox"/> Rental by client, with RRH or equivalent subsidy
<input type="checkbox"/> Jail, prison, or juvenile detention facility	<input type="checkbox"/> Rental by client, with HCV voucher (also NED/FUV)
<input type="checkbox"/> Long-term care facility or nursing home	<input type="checkbox"/> Rental by client in a public housing unit
<input type="checkbox"/> Psychiatric hospital or other psychiatric facility	<input type="checkbox"/> Rental by client, no housing subsidy
<input type="checkbox"/> Substance abuse treatment facility or detox center	<input type="checkbox"/> Owned by client, with ongoing housing subsidy
<input type="checkbox"/> Residential or halfway house w/o homeless criteria	<input type="checkbox"/> Owned by client, no housing subsidy
<input type="checkbox"/> Hotel without voucher	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Transitional housing	<input type="checkbox"/> Do not know <input type="checkbox"/> Refused
<input type="checkbox"/> Host home	
<input type="checkbox"/> Staying or living in a friend's room, apartment or house	

### Length of Stay in Prior Living Situation:

- |  |  |
|--|--|
| <input type="checkbox"/> One night or less                         | <input type="checkbox"/> 90 days or more, but less than one year |
| <input type="checkbox"/> Two or to six nights                      | <input type="checkbox"/> One Year or longer                      |
| <input type="checkbox"/> One week or more, but less than one month | <input type="checkbox"/> Doesn't Know                            |
| <input type="checkbox"/> One month or more, but less than 90 days  | <input type="checkbox"/> Refused                                 |

**Approximate Date Homelessness Started:** \_\_\_/\_\_\_/\_\_\_

**\*\*Note:** The above date is the start of **current** episode of literal homelessness (place not meant for habitation, emergency shelter, or Safe Haven only). If client is not entering from literal homelessness, please leave blank. \*\*

### Number of times the client has been on the streets, in Emergency Shelter, or Safe Haven in the past three years:

- One Time     Two Times     Three Times     Four or more times     Doesn't Know     Refused

**Total number of months homeless on the street or in Emergency Shelter in the past three years:** \_\_\_\_\_

**Length of Time Homeless - Status Documented?**     Yes     No     Doesn't Know     Refused





## Disabling Conditions

<b>Physical Condition</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused	<b>If yes, is it a long-term condition?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused
<b>Developmental Disability</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused	
<b>Chronic Health Condition</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused	<b>If yes, is it a long-term condition?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused
<b>HIV - AIDS</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused	
<b>Mental Health Disorder</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused	<b>If yes, is it a long-term condition?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused
<b>Substance Use Disorder</b>	<input type="checkbox"/> Yes, Alcohol Use Disorder <input type="checkbox"/> Yes, Drug Use Disorder <input type="checkbox"/> Yes, Both Alcohol and Drug Use Disorders	<input type="checkbox"/> No <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Refused

## Domestic Violence

Has the client experienced domestic violence?  Yes     No     Doesn't Know     Refused

If yes, when did the experience occur (in months/years): \_\_\_\_\_

If yes, are they currently fleeing:             Yes     No     Doesn't Know     Refused



## Income

Is there income received from any source in the past 30 days?  Yes  No  Doesn't Know  Refused

If yes, continue below and if not, skip this section.

<b>Earned Income</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused	\$
<b>Unemployment Insurance</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused	\$
<b>SSI</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused	\$
<b>SSDI</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused	\$
<b>VA Service-Connected Disability</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused	\$
<b>VA Non-Service Disability Pension</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused	\$
<b>Workers Compensation</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused	\$
<b>TANF/ReachUP</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused	\$
<b>General Assistance (GA)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused	\$
<b>Retirement Income from SS</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused	\$
<b>Former Job Pension/Retirement</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused	\$
<b>Child Support</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused	\$
<b>Alimony and Other Spousal Support</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused	\$
<b>Other</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused	\$
<b>Total</b>					\$

## Non-Cash Benefits

Does the client receive any non-cash benefits?  Yes  No  Doesn't Know  Refused

If yes, continue below and if not, skip this section.

<b>SNAP/3 Squares</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused
<b>WIC</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused
<b>TANF Childcare Services</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused
<b>TANF Transportation Services</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused
<b>Other TANF-Funded Services</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused
<b>Other Source</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused



## Health Insurance Information

Health insurance received from any source in the last 30 days?  Yes  No  Doesn't Know  Refused

If yes, continue below and if not, skip this section.

Medicaid	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused
Medicare	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused
State Children Health Insurance Program	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused
VA Medical Services	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused
Employer – Provided Health Insurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused
COBRA	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused
Private Pay Health Insurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused
State Health Insurance for Adults	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused
Indian Health Services Program	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused
Other Health Insurance: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't Know	<input type="checkbox"/> Refused

## Questions for Family Supportive Housing

Do you currently have an open case with DCF Services?  Yes  No

If yes, are any children placed outside of the home?  Yes  No

If yes, what is the date of birth of the youngest child placed outside of the home?

Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_