

Staff: \_\_\_\_\_ Project Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Name of Head of Household: \_\_\_\_\_

Project Name (Enter Data As): \_\_\_\_\_

**Client Record**

Unless specifically required by a funder, clients may use a preferred name (rather than legal name) for HMIS purposes.

**Name** \_\_\_\_\_

First Middle Last Suffix

**Name Data Quality** ☐ Full Name Reported ☐ Partial, Street Name, or Code Name Reported

☐ Client doesn't know ☐ Client prefers not to answer



Best practice is to collect all nine digits of the SSN for all clients; CoC-, ESG-, and PATH-funded projects are only required to attempt to collect the last four digits of the SSN. Other projects must attempt to collect all nine digits of the SSN, though clients can refuse all or part of the SSN. Unless explicitly requested by the client, the first five digits of the SSN should not be deleted if previously recorded in HMIS.

**Social Security Number**

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

☐ Full SSN Reported ☐ Approximate or Partial SSN Reported ☐ Client doesn't know ☐ Client prefers not to answer

**U.S. Veteran** ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer**Client Demographics**

**Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_

☐ Full DOB Reported ☐ Approximate or Partial DOB Reported ☐ Client doesn't know ☐ Client prefers not to answer

**Sex** ☐ Female ☐ Male

☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

**Race(s) and Ethnicity** *select all that apply*

☐ American Indian, Alaska Native, or Indigenous ☐ Asian or Asian American

☐ Black, African American, or African ☐ Hispanic/Latina/o

☐ Middle Eastern or North African ☐ Native Hawaiian or Pacific Islander

☐ White ☐ Client doesn't know

☐ Client prefers not to answer

**Additional Race & Ethnicity**  
optional, specify

\_\_\_\_\_

\_\_\_\_\_

**Relationship to Head of Household** ☐ Self ☐ Head of household's child


☐ Head of household's spouse or partner ☐ Other: non-relation member

☐ Head of household's other relation member (other relation to head of household)

## RHY Basic Center Program Status


Date of Status Determination	____/____/____			
Youth Eligible for RHY Services	<input type="checkbox"/> No <input type="checkbox"/> Yes			
If no, reason why services are not funded by BCP grant	<input type="checkbox"/> Out of age range <input type="checkbox"/> Ward of the State – Immediate Reunification <input type="checkbox"/> Ward of the Criminal Justice System – Immediate Reunification <input type="checkbox"/> Other			
If yes, runaway youth	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
Enrollment CoC	<input type="checkbox"/> MO-500 St. Louis County <input type="checkbox"/> MO-600 Springfield/Greene, Christian, Webster Counties <input type="checkbox"/> MO-603 St. Joseph/Andrew, Buchanan, DeKalb Counties		<input type="checkbox"/> MO-501 St. Louis City <input type="checkbox"/> MO-602 Joplin/Jasper, Newton Counties <input type="checkbox"/> MO-606 Missouri Balance of State	

## Client location as of assessment/review date

	Select the county in which the client is residing (or sleeping at night if unhoused). This field does not need to match the CoC Code above.
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Client Location (County) \_\_\_\_\_

## Last Permanent Address

	Record the last zip code the client had for at least 90 days that was not in an emergency shelter, a transitional housing project, a safe haven, or a place not meant for habitation.
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Zip Code of Last Permanent Address \_\_\_\_\_  
☐ Full or Partial Zip Code Reported ☐ Client doesn't know ☐ Client prefers not to answer


## Disabilities


Disabling Condition ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

## Health Insurance


Covered by Health Insurance ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

Medicaid (MO HealthNet)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Medicare	<input type="checkbox"/> No	<input type="checkbox"/> Yes
State Children's Health Insurance Program	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Veteran's Health Administration	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Employer-Provided Health Insurance	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Health Insurance obtained through COBRA	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Private Pay Health Insurance	<input type="checkbox"/> No	<input type="checkbox"/> Yes
State Health Insurance for Adults	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Indian Health Services Program	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Other (specify): _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes

	HUD requires that the client be asked about each individual source of health insurance and requires an answer be recorded for each.
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	<b>Data Entry Tip:</b> Remember to end date old records and create new records each time a source of health insurance changes.
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## Disabilities

	If one or more of the options below with an asterisk(*) has been selected, the answer to "disabling condition" must be "yes." If none of the answers below with an asterisk(*) has been selected, the answer to "disabling condition" may be "yes" or "no."
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Disability type	Disability determination	If yes, expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?
Alcohol Use Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Ref
Both Alcohol and Drug Use Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Ref
Chronic Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> Ref
Developmental Disability	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	(not applicable)

Drug Use Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> PNTA	<input type="checkbox"/> Yes*	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Ref
HIV/AIDS	<input type="checkbox"/> Yes*	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> PNTA	<i>(not applicable)</i>			
Mental Health Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> PNTA	<input type="checkbox"/> Yes*	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Ref
Physical Disability	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> PNTA	<input type="checkbox"/> Yes*	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Ref

DK = Client doesn't know; PNTA = Client prefers not to answer