

Staff: _____ Project Start Date: ____/____/____ Name of Head of Household: _____

Project Name (Enter Data As): _____

Client Record

i 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

i 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)


Project CoC Code

 If you're unsure which CoC code to select for your project, reach out to the helpdesk for assistance.

Enrollment CoC


<input type="checkbox"/> MO-500 St. Louis County	<input type="checkbox"/> MO-501 St. Louis City
<input type="checkbox"/> MO-600 Springfield/Greene, Christian, Webster Counties	<input type="checkbox"/> MO-602 Joplin/Jasper, Newton Counties
<input type="checkbox"/> MO-603 St. Joseph/Andrew, Buchanan, DeKalb 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.

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.

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.

 **Data Entry Tip:**
Remember to end date old records and create new records each time a source of health insurance changes.

Monthly Income

Income from Any Source ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

Alimony and other spousal support	<input type="checkbox"/> No <input type="checkbox"/> Yes: \$ _____
Child support	<input type="checkbox"/> No <input type="checkbox"/> Yes: \$ _____
Earned income (i.e., employment income)	<input type="checkbox"/> No <input type="checkbox"/> Yes: \$ _____
General Assistance (GA)	<input type="checkbox"/> No <input type="checkbox"/> Yes: \$ _____
Other (specify): _____	<input type="checkbox"/> No <input type="checkbox"/> Yes: \$ _____
Pension or retirement income from a former job	<input type="checkbox"/> No <input type="checkbox"/> Yes: \$ _____
Private disability insurance	<input type="checkbox"/> No <input type="checkbox"/> Yes: \$ _____

 HUD requires that the client be asked about each individual source of income and requires an answer be recorded for each. For any income sources where income is received, the monthly amount must also be recorded.

Retirement Income from Social Security	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Social Security Disability Insurance (SSDI)	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Supplemental Security Income (SSI)	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Temporary Assistance for Needy Families (TANF)	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Unemployment Insurance	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
VA Non-Service-Connected Disability Pension	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
VA Service-Connected Disability Compensation	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Worker's Compensation	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____

①

Data Entry Tip:

Remember to end date old records and create new records each time a source of income changes.

Total Monthly Income \$ _____

Non-Cash Benefits

Non-Cash Benefits from Any Source ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

Supplemental Nutrition Assistance Program (SNAP)
(Previously known as Food Stamps) ☐ No ☐ Yes

Special Supplemental Nutrition Program for
Women, Infants and Children (WIC) ☐ No ☐ Yes

TANF Child Care services ☐ No ☐ Yes

TANF transportation services ☐ No ☐ Yes

Other TANF-funded services ☐ No ☐ Yes

Other (specify): _____ ☐ No ☐ Yes

①

HUD requires that the client be asked about each individual source of non-cash benefits and requires an answer be recorded for each.

①

Data Entry Tip:

Remember to end date old records and create new records each time a source of non-cash benefit changes.

Chronic Homelessness Determination

Prior living situation (Where did the client stay immediately prior to entry?)

Homeless situations (if none of these options match, skip to "Institutional situations")

- ☐ Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)
- ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher, host home shelter
- ☐ Safe haven

Length of stay in homeless situation noted above

- | | |
|--|--|
| <input type="checkbox"/> One night or less | <input type="checkbox"/> 90 days or more, but less than one year |
| <input type="checkbox"/> Two 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"/> Client doesn't know |
| <input type="checkbox"/> One month or more, but less than 90 days | <input type="checkbox"/> Client prefers not to answer |

Skip to "Approximate date homelessness started" (below)

Institutional situations (if none of these options match, skip to "Temporary housing situations")

- | | |
|---|---|
| <input type="checkbox"/> Foster care home or foster care group home | <input type="checkbox"/> Long-term care facility or nursing home |
| <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility | <input type="checkbox"/> Psychiatric hospital or other psychiatric facility |
| <input type="checkbox"/> Jail, prison or juvenile detention facility | <input type="checkbox"/> Substance abuse treatment facility or detox center |

Length of stay in institutional situation noted above

- | | |
|---|--|
| <input type="checkbox"/> <u>One night or less</u> | <input type="checkbox"/> 90 days or more, but less than one year |
| <input type="checkbox"/> <u>Two to six nights</u> | <input type="checkbox"/> One year or longer |
| <input type="checkbox"/> <u>One week or more, but less than one month</u> | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> <u>One month or more, but less than 90 days</u> | <input type="checkbox"/> Client prefers not to answer |

If you selected one of the underlined options above, were they on the streets or in emergency shelter prior to that? ☐ No ☐ Yes

If yes, skip to "Approximate date homelessness started" (below)

If no, skip to next section

Temporary housing situations (if none of these options match, skip to “Permanent housing situations”)

- | | |
|---|---|
| <input type="checkbox"/> Residential project or halfway house with no homeless criteria | <input type="checkbox"/> Host home (non-crisis) |
| <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher | <input type="checkbox"/> Staying or living in a friend’s room, apartment, or house |
| <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) | <input type="checkbox"/> Staying or living in a family member’s room, apartment, or house |

Length of stay in temporary situation noted above

- | | |
|--|--|
| <input type="checkbox"/> <u>One night or less</u> | <input type="checkbox"/> 90 days or more, but less than one year |
| <input type="checkbox"/> <u>Two to six nights</u> | <input type="checkbox"/> One year or longer |
| <input type="checkbox"/> One week or more, but less than one month | <input type="checkbox"/> Client doesn’t know |
| <input type="checkbox"/> One month or more, but less than 90 days | <input type="checkbox"/> Client prefers not to answer |

If you selected one of the underlined options above, were they on the streets or in emergency shelter prior to that? ☐ No ☐ Yes

If yes, skip to “Approximate date homelessness started” (below)

If no, skip to next section

Permanent housing situations (if none of these options match, skip to “Other”)

- | | |
|--|--|
| <input type="checkbox"/> Rental by client, no ongoing housing subsidy | <i>If “rental by client, with ongoing subsidy”, select type</i> |
| <input type="checkbox"/> Rental by client, with ongoing subsidy (<u>select subsidy type</u>) | <input type="checkbox"/> GPD TIP housing subsidy |
| <input type="checkbox"/> Owned by client, with ongoing housing subsidy | <input type="checkbox"/> VASH housing subsidy |
| <input type="checkbox"/> Owned by client, no ongoing housing subsidy | <input type="checkbox"/> RRH or equivalent subsidy |
| | <input type="checkbox"/> HCV Voucher (tenant or project based) |
| | <input type="checkbox"/> Public housing unit |
| | <input type="checkbox"/> Rental by client, with other ongoing housing subsidy |
| | <input type="checkbox"/> Housing Stability Voucher |
| | <input type="checkbox"/> Family Unification Program Voucher (FUP) |
| | <input type="checkbox"/> Foster Youth to Independence Initiative (FYI) |
| | <input type="checkbox"/> Permanent Supportive Housing |
| | <input type="checkbox"/> Other permanent housing dedicated for formerly homeless persons |

Length of stay in permanent situation noted above

- | | |
|--|--|
| <input type="checkbox"/> One night or less | <input type="checkbox"/> 90 days or more, but less than one year |
| <input type="checkbox"/> Two 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"/> Client doesn’t know |
| <input type="checkbox"/> One month or more, but less than 90 days | <input type="checkbox"/> Client prefers not to answer |

Other

- | | |
|--|---|
| <input type="checkbox"/> Client doesn’t know | <input type="checkbox"/> Client prefers not to answer |
|--|---|

Skip to next section

Approximate date this episode of homelessness started: ____/____/____

Regardless of where they stayed last night, number of times on streets, in ES, or SH in the past 3 years including today

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> One time | <input type="checkbox"/> Three times | <input type="checkbox"/> Client doesn’t know |
| <input type="checkbox"/> Two times | <input type="checkbox"/> Four or more times | <input type="checkbox"/> Client prefers not to answer |

Total number of months homeless on the street, in ES, or SH in the past 3 years

- | | | | |
|---|----------------------------|-----------------------------|---|
| <input type="checkbox"/> One month (this time is the first month) | <input type="checkbox"/> 5 | <input type="checkbox"/> 9 | <input type="checkbox"/> More than 12 months |
| <input type="checkbox"/> 2 | <input type="checkbox"/> 6 | <input type="checkbox"/> 10 | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> 3 | <input type="checkbox"/> 7 | <input type="checkbox"/> 11 | <input type="checkbox"/> Client prefers not to answer |
| <input type="checkbox"/> 4 | <input type="checkbox"/> 8 | <input type="checkbox"/> 12 | |

Education

- | | | | |
|----------------------|---|---|---|
| School Status | <input type="checkbox"/> Attending School Regularly | <input type="checkbox"/> Attending School Irregularly | <input type="checkbox"/> Graduated High School |
| | <input type="checkbox"/> Obtained GED (incl. HiSET) | <input type="checkbox"/> Dropped Out | <input type="checkbox"/> Suspended |
| | <input type="checkbox"/> Expelled | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Client prefers not to answer |

- | | | | |
|-----------------------------|--|---|--|
| Last Grade Completed | <input type="checkbox"/> Less than Grade 5 | <input type="checkbox"/> Grades 5-6 | <input type="checkbox"/> Grades 7-8 |
| | <input type="checkbox"/> Grades 9-11 | <input type="checkbox"/> Grade 12/High School Diploma | <input type="checkbox"/> School program does not have grade levels |
| | <input type="checkbox"/> GED (incl. HiSET) | <input type="checkbox"/> Some College | <input type="checkbox"/> Associate's Degree |
| | <input type="checkbox"/> Bachelor's Degree | <input type="checkbox"/> Graduate Degree | <input type="checkbox"/> Vocational Certification |
| | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Client prefers not to answer | |

Employment

- | | | | | |
|------------------|-----------------------------|------------------------------|--|---|
| Employed? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Client prefers not to answer |
|------------------|-----------------------------|------------------------------|--|---|

If yes, type of employment:☐ Full-Time☐ Part-Time☐ Seasonal/Sporadic (including Day Labor)**If no, why not employed:**☐ Looking for Work☐ Unable to Work☐ Not Looking for Work**Health**

- | | | | | | |
|------------------------------|--|---|-------------------------------|-------------------------------|-------------------------------|
| General Health Status | <input type="checkbox"/> Excellent | <input type="checkbox"/> Very Good | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Client prefers not to answer | | | |

- | | | | | | |
|-----------------------------|--|---|-------------------------------|-------------------------------|-------------------------------|
| Dental Health Status | <input type="checkbox"/> Excellent | <input type="checkbox"/> Very Good | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Client prefers not to answer | | | |

- | | | | | | |
|-----------------------------|--|---|-------------------------------|-------------------------------|-------------------------------|
| Mental Health Status | <input type="checkbox"/> Excellent | <input type="checkbox"/> Very Good | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Client prefers not to answer | | | |

- | | | | | |
|-------------------------|-----------------------------|------------------------------|--|---|
| Pregnancy Status | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Client prefers not to answer |
|-------------------------|-----------------------------|------------------------------|--|---|

If yes, due date ____/____/____**Child Welfare/Foster Care Involvement**

- | | | | | |
|---|-----------------------------|------------------------------|--|---|
| Formerly a Ward of Child Welfare or Foster Care Agency | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Client prefers not to answer |
|---|-----------------------------|------------------------------|--|---|

If yes, number of years☐ Less than one year☐ 1 to 2 years☐ 3 to 5 or more years**If less than one year, number of months** ____ months (1-11)**Juvenile Justice System Involvement**

- | | | | | |
|---|-----------------------------|------------------------------|--|---|
| Formerly a Ward of Juvenile Justice System | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Client prefers not to answer |
|---|-----------------------------|------------------------------|--|---|

If yes, number of years☐ Less than one year☐ 1 to 2 years☐ 3 to 5 or more years**If less than one year, number of months** ____ months (1-11)

Family Critical Issues

i HUD expects that the client be asked about each individual family critical issue and requires an answer be recorded for each.

Unemployment – Family member	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Data Not Collected
Mental Health Disorder – Family member	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Data Not Collected
Physical Disability – Family member	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Data Not Collected
Alcohol or Substance Use Disorder – Family member	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Data Not Collected
Insufficient Income to support youth – Family member	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Data Not Collected
Incarcerated Parent of Youth	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Data Not Collected

Referral Source (RHY)

Referral Source	<input type="checkbox"/> Self-Referral	<input type="checkbox"/> Individual: Parent/Guardian/Relative/Friend/Foster Parent/Other Individual	
	<input type="checkbox"/> Outreach Project	<input type="checkbox"/> Temporary Shelter	<input type="checkbox"/> Residential Project
	<input type="checkbox"/> Hotline	<input type="checkbox"/> Child Welfare/CPS	<input type="checkbox"/> Juvenile Justice
	<input type="checkbox"/> Law Enforcement/Police	<input type="checkbox"/> Mental Hospital	<input type="checkbox"/> School
	<input type="checkbox"/> Other Organization	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer

Disabilities

i 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.”

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"/> PNTA
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"/> PNTA
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"/> PNTA
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"/> PNTA
HIV/AIDS	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	(not applicable)
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"/> PNTA
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"/> PNTA

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

Domestic Violence

i “Domestic violence” is utilized here as shorthand for domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions that relate to violence against the individual or a family member.

Survivor of Domestic Violence? ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

If yes, when experience occurred	<input type="checkbox"/> Within the past three months	<input type="checkbox"/> Three to six months ago
	<input type="checkbox"/> From six to twelve months ago	<input type="checkbox"/> More than a year ago
	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer

If yes, currently fleeing? ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

BE SURE TO LOG ANY RHY SPECIFIC SERVICES THAT WERE PROVIDED AT THE TIME OF ENTRY!