

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 Profile Additional Information [Optional]****Contact Information** \_\_\_\_\_**Emergency Contact** \_\_\_\_\_**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****i** If you're unsure which CoC code to select for your project, reach out to the helpdesk for assistance.

**Enrollment CoC** ☐ MO-500 St. Louis County ☐ MO-501 St. Louis City

☐ MO-600 Springfield/Greene, Christian, Webster Counties ☐ MO-602 Joplin/Jasper, Newton Counties

☐ MO-603 St. Joseph/Andrew, Buchanan, DeKalb Counties ☐ MO-606 Missouri Balance of State

### Client location as of assessment/review date

**i** 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

**i** 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

### Housing Move-In Date

**i** Record the date of the first night the head of household spent living in the unit for permanent housing projects (incl. PSH, RRH, and OPH). This must be on or after the project start date. Leave blank if the client is not yet housed.

**Housing Move-In Date** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

### 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

**i** HUD requires that the client be asked about each individual source of health insurance and requires an answer be recorded for each.

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