

ICA Missouri – YHDP Start – Joint Component TH-RRH Practice Case Part 1 [FY2024] Adult/HoH
A parenting youth is presenting for services to your agency. After talking with the client, you have confirmed this family will be part of your agency's joint component Transitional Housing (TH) and Rapid ReHousing (RRH) projects. They are residing in your TH project, but do NOT have a move-in date for permanent housing with RRH assistance yet. The HMIS ROI was signed for 1 year. YOU WILL START BY ENTERING DATA IN THE TH PROJECT. BE SURE TO SET YOUR ENTER DATA AS (EDA) MODE TO THE TH PROJECT BEFORE ENTERING THE INFORMATION BELOW!!!!

Staff: _____ Project Start Date: [The 1st of two months ago] Name of Head of Household: Charlie [use your last name]

Project Name (Enter Data As): [Use TH project name provided in email as EDA]

Client Record

i	Unless specifically required by a funder, clients may use a preferred name (rather than legal name) for HMIS purposes.
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Name Charlie [your last 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.
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Social Security Number [make up a SSN]
☒ 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 make up a phone number for the client

Emergency Contact Ryan, her brother [make up a phone number]

Client Demographics

Date of Birth 03 / 22 / 2005
☒ Full DOB Reported ☐ Approximate or Partial DOB Reported ☐ Client doesn't know ☐ Client prefers not to answer

Gender(s) ☒ Woman (Girl, if child) ☐ Man (Boy, if child) ☐ Culturally Specific Identity (e.g. Two-Spirit)
select all that apply ☐ Transgender ☐ Non-Binary ☐ Questioning
☐ Different Identity (specify): ☐ Client doesn't know ☐ Client prefers not to answer

Race(s) and Ethnicity ☐ American Indian, Alaska Native, or Indigenous ☒ Asian or Asian American
select all that apply ☐ Black, African American, or African ☐ Hispanic/Latina/e/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)

Household Information

Household Type £ Couple w/o Children ☒ Female Single Parent £ Foster Parent £ Grandparent with Child
£ Male Single Parent £ Non-custodial Caregiver £ Single Person £ Female Single Parent

Full Name	Veteran Yes or No	SSN (full or partial)	Date of Birth	Race and Ethnicity	Gender	Relationship to HoH
Charlie [your last name]	No	Make up a full SSN	3/22/2005	Asian or Asian American	Woman	Self (head of household)
Jamie [your last name]	No	Make up a full SSN	3/1/2023	Asian or Asian American	Girl	Daughter/HoH's child

Project CoC Code [mark the appropriate 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) [mark the County your client is residing in]

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 63114
☒ 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 [Rapid ReHousing projects only]

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 [this is not entered for TH project]

Health Insurance

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

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

Monthly Income

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

Alimony and other spousal support	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Child support	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Earned income (i.e., employment income)	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
General Assistance (GA)	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Other (specify): _____	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Pension or retirement income from a former job	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Private disability insurance	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Retirement Income from Social Security	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Social Security Disability Insurance (SSDI)	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Supplemental Security Income (SSI)	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Temporary Assistance for Needy Families (TANF)	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Unemployment Insurance	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
VA Non-Service-Connected Disability Pension	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
VA Service-Connected Disability Compensation	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Worker's Compensation	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____

Total Monthly Income \$ 0

i 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.

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

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)	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes
Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
TANF Child Care services	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
TANF transportation services	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
Other TANF-funded services	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
Other (specify): _____	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes

i HUD requires that the client be asked about each individual source of non-cash benefits 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 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

☒ One night or less

☐ Two to six nights

☐ One week or more, but less than one month

☐ One month or more, but less than 90 days

Skip to "Approximate date homelessness started" (below)

☐ 90 days or more, but less than one year

☐ One year or longer

☐ Client doesn't know

☐ Client prefers not to answer

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

☐ Foster care home or foster care group home

☐ Hospital or other residential non-psychiatric medical facility

☐ Jail, prison or juvenile detention facility

☐ Long-term care facility or nursing home

☐ Psychiatric hospital or other psychiatric facility

☐ Substance abuse treatment facility or detox center

Length of stay in institutional situation noted above

☐ One night or less

☐ Two to six nights

☐ One week or more, but less than one month

☐ One month or more, but less than 90 days

☐ 90 days or more, but less than one year

☐ One year or longer

☐ Client doesn't know

☐ 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")

☐ Residential project or halfway house with no homeless criteria

☐ Hotel or motel paid for without emergency shelter voucher

☐ Transitional housing for homeless persons (including homeless youth)

☐ Host home (non-crisis)

☐ Staying or living in a friend's room, apartment, or house

☐ Staying or living in a family member's room, apartment, or house

Length of stay in temporary situation noted above

☐ One night or less

☐ Two to six nights

☐ One week or more, but less than one month

☐ One month or more, but less than 90 days

☐ 90 days or more, but less than one year

☐ One year or longer

☐ Client doesn't know

☐ 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")

☐ Rental by client, no ongoing housing subsidy

☐ Rental by client, with ongoing subsidy (select subsidy type)

☐ Owned by client, with ongoing housing subsidy

☐ Owned by client, no ongoing housing subsidy

If "rental by client, with ongoing subsidy", select type

☐ GPD TIP housing subsidy

☐ VASH housing subsidy

☐ RRH or equivalent subsidy

☐ HCV Voucher (tenant or project based)

☐ Public housing unit

☐ Rental by client, with other ongoing housing subsidy

☐ Housing Stability Voucher

☐ Family Unification Program Voucher (FUP)

☐ Foster Youth to Independence Initiative (FYI)

☐ Permanent Supportive Housing

☐ Other permanent housing dedicated for formerly homeless persons

Length of stay in permanent situation noted above

☐ One night or less

☐ Two to six nights

☐ One week or more, but less than one month

☐ One month or more, but less than 90 days

☐ 90 days or more, but less than one year

☐ One year or longer

☐ Client doesn't know

☐ 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

Other

☐ Client doesn't know

☐ Client prefers not to answer

Skip to next section

Approximate date this episode of homelessness started: December 1st of last year

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

<input checked="" 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 **[Please choose the number of months between the above December date and the entry date]**

<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	

Sexual Orientation

Sexual Orientation	<input type="checkbox"/> Heterosexual	<input type="checkbox"/> Gay	<input type="checkbox"/> Lesbian	<input checked="" type="checkbox"/> Bisexual
	<input type="checkbox"/> Questioning/Unsure	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Other: _____

Health

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

Pregnancy Status ☐ No ☒ Yes ☐ Client doesn't know ☐ Client prefers not to answer

If yes, due date **[4 months from the project entry]**

Child Welfare/Foster Care Involvement

Formerly a Ward of Child Welfare or Foster Care Agency	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
If yes, number of years	<input checked="" type="checkbox"/> Less than one year	<input type="checkbox"/> 1 to 2 years	<input type="checkbox"/> 3 to 5 or more years	
If less than one year, number of months	<u>6</u> months (1-11)			

Juvenile Justice System Involvement

Formerly a Ward of Juvenile Justice System	<input checked="" 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	<input type="checkbox"/> Less than one year	<input type="checkbox"/> 1 to 2 years	<input type="checkbox"/> 3 to 5 or more years	
If less than one year, number of months	_____ months (1-11)			

Translation Assistance [Head of Household Only]

Translation Assistance Needed?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
If yes to "Translation Assistance Needed?", select preferred language:	<input type="checkbox"/> American Sign Language	<input type="checkbox"/> Arabic	<input type="checkbox"/> Bosnian	
	<input type="checkbox"/> Burmese	<input type="checkbox"/> Cantonese	<input type="checkbox"/> Chuukese	
	<input type="checkbox"/> Dinka	<input type="checkbox"/> Farsi	<input type="checkbox"/> French	
	<input type="checkbox"/> German	<input type="checkbox"/> Mandarin	<input type="checkbox"/> Romanian	
	<input type="checkbox"/> Russian	<input type="checkbox"/> Spanish	<input type="checkbox"/> Tagalog	
	<input type="checkbox"/> Tigrigna	<input type="checkbox"/> Ukrainian	<input type="checkbox"/> Urdu	
	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Different Preferred Language (specify): _____		
	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer		

Youth Education Status [Head of Household Only]

Current School Enrollment and Attendance	✗ Not currently enrolled in any school or educational course	£ Client doesn't know	
		£ Client prefers not to answer	
	£ Currently enrolled but NOT attending regularly (when school or the course is in session)	£ Data not collected	
	£ Currently enrolled and attending regularly (when school or the course is in session)		
Most Recent Educational Status	£ K12: Graduated from high school	£ Higher education: pursuing a credential but not currently attending	£ Client doesn't know
	£ K12: Obtained GED		£ Client prefers not to answer
	✗ K12: Dropped out	£ Higher Education: Dropped out	£ Data not collected
	£ K12: Suspended	£ Higher Education: Obtained a credential/degree	
	£ K12: Expelled		
Current Educational Status	£ Pursuing a diploma or GED	£ Client doesn't know	
	£ Pursuing Associate's Degree	£ Client prefers not to answer	
	£ Pursuing Bachelor's Degree	£ Data not collected	
	£ Pursuing Graduate Degree		
	£ Pursuing other post-secondary credential		

Disabilities

i	<p>If one or more of the options below with an asterisk(*) has been selected, the answer to "disabling condition" must be "yes."</p> <p>If none of the answers below with an asterisk(*) has been selected, the answer to "disabling condition" may be "yes" or "no."</p>
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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 checked="" 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 checked="" 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 checked="" 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 checked="" type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	(not applicable)			
Drug Use Disorder	<input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	(not applicable)			
Mental Health Disorder	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	<input checked="" type="checkbox"/> Yes*	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> PNTA
Physical Disability	<input type="checkbox"/> Yes <input checked="" 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	<p>"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.</p>
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Survivor of Domestic Violence? ☒ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

If yes, when experience occurred	<p><input type="checkbox"/> Within the past three months</p> <p><input type="checkbox"/> From six to twelve months ago</p> <p><input type="checkbox"/> Client doesn't know</p>	<p><input type="checkbox"/> Three to six months ago</p> <p><input type="checkbox"/> More than a year ago</p> <p><input type="checkbox"/> Client prefers not to answer</p>
If yes, currently fleeing?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer

ICA Missouri – YHDP Start – Joint Component TH-RRH Practice Case Part 1 [FY2024] Child

Your client has a child for which you need to include in the household and in the project entry. Below is the child's information at intake. Be sure to enter the information listed.

Staff: _____ Project Start Date: [The 1st of two months ago] Name of Head of Household: Charlie [use your last name]

Project Name (Enter Data As): [Use TH project name provided in email as EDA]

Client Record

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

Name Jamie [use your last 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 [make up a SSN]

☒ 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 03 / 01 / 2023

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

Gender(s) ☒ Woman (Girl, if child) ☐ Man (Boy, if child) ☐ Culturally Specific Identity (e.g. Two-Spirit)
select all that apply ☐ Transgender ☐ Non-Binary ☐ Questioning
☐ Different Identity (specify): ☐ Client doesn't know ☐ Client prefers not to answer

Race(s) and Ethnicity ☐ American Indian, Alaska Native, or Indigenous ☒ Asian or Asian American
select all that apply ☐ Black, African American, or African ☐ Hispanic/Latina/e/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 [mark the appropriate 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) [mark the County your client is residing in]

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 63114

☒ 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 [Rapid ReHousing projects only]

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 [this is not entered for TH projects]

Health Insurance

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

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

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	£ Yes	<input checked="" type="checkbox"/> No	£ DK	£ PNTA	£ Yes*	£ No	£ DK	£ PNTA
Both Alcohol and Drug Use Disorders	£ Yes	<input checked="" type="checkbox"/> No	£ DK	£ PNTA	£ Yes*	£ No	£ DK	£ PNTA
Chronic Health Condition	£ Yes	<input checked="" type="checkbox"/> No	£ DK	£ PNTA	£ Yes*	£ No	£ DK	£ PNTA
Developmental Disability	£ Yes*	<input checked="" type="checkbox"/> No	£ DK	£ PNTA	(not applicable)			
Drug Use Disorder	£ Yes	<input checked="" type="checkbox"/> No	£ DK	£ PNTA	£ Yes*	£ No	£ DK	£ PNTA
HIV/AIDS	£ Yes*	<input checked="" type="checkbox"/> No	£ DK	£ PNTA	(not applicable)			
Mental Health Disorder	£ Yes	<input checked="" type="checkbox"/> No	£ DK	£ PNTA	£ Yes*	£ No	£ DK	£ PNTA
Physical Disability	£ Yes	<input checked="" type="checkbox"/> No	£ DK	£ PNTA	£ Yes*	£ No	£ DK	£ PNTA

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

Your project does not require recording services. Continue for Client's RRH intake.

ICA Missouri – YHDP Start – Joint Component TH-RRH Practice Case Part 1 [FY2024] Adult/HoH
You will now create an entry for the household in the Joint Component RRH Project. BE SURE TO SET YOUR ENTER DATA AS (EDA) MODE TO THE JOINT RRH PROJECT!!!! Search for Client's Name or ID. The HMIS ROI was signed for 1 year. Confirm information below in the Client Profile tab. Then, Add Entry WITH BOTH MEMBERS OF THE HOUSEHOLD SELECTED in the Entry / Exit tab and confirm information below.

Staff: _____ Project Start Date: [The 1st of two months ago] Name of Head of Household: Charlie [use your last name]

Project Name (Enter Data As): [Use RRH project name provided in email as EDA]

Client Record

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

Name Charlie [your last 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

[make up a SSN]

☒ 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 make up a phone number for the client

Emergency Contact Ryan, her brother [make up a phone number]

Client Demographics

Date of Birth 03 / 22 / 2005

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

Gender(s) *select all that apply* ☒ Woman (Girl, if child) ☐ Man (Boy, if child) ☐ Culturally Specific Identity (e.g. Two-Spirit)
☐ Transgender ☐ Non-Binary ☐ Questioning
☐ Different Identity (specify): _____ ☐ Client doesn't know ☐ Client prefers not to answer

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/e/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)

Household Information

Household Type £ Couple w/o Children ☒ Female Single Parent £ Foster Parent £ Grandparent with Child
 £ Male Single Parent £ Non-custodial Caregiver £ Single Person £ Female Single Parent

Full Name	Veteran Yes or No	SSN (full or partial)	Date of Birth	Race and Ethnicity	Gender	Relationship to HoH
Charlie [your last name]	No	Make up a full SSN	3/22/2005	Asian or Asian American	Woman	Self (head of household)
Jamie [your last name]	No	Make up a full SSN	3/1/2023	Asian or Asian American	Girl	Daughter/HoH's child

Project CoC Code [mark the appropriate 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) [mark the County your client is residing in]

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 63114
 ☒ 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 [Rapid ReHousing projects only]

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 [leave blank until they receive a move-in date]

Health Insurance

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

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

Monthly Income

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

Alimony and other spousal support	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Child support	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Earned income (i.e., employment income)	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
General Assistance (GA)	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Other (specify): _____	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Pension or retirement income from a former job	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Private disability insurance	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Retirement Income from Social Security	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Social Security Disability Insurance (SSDI)	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Supplemental Security Income (SSI)	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Temporary Assistance for Needy Families (TANF)	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Unemployment Insurance	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
VA Non-Service-Connected Disability Pension	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
VA Service-Connected Disability Compensation	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Worker's Compensation	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____

Total Monthly Income \$ 0

i 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.

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

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)	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes
Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
TANF Child Care services	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
TANF transportation services	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
Other TANF-funded services	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes
Other (specify): _____	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes

i HUD requires that the client be asked about each individual source of non-cash benefits 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 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

☒ One night or less

☐ Two to six nights

☐ One week or more, but less than one month

☐ One month or more, but less than 90 days

Skip to "Approximate date homelessness started" (below)

☐ 90 days or more, but less than one year

☐ One year or longer

☐ Client doesn't know

☐ Client prefers not to answer

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

☐ Foster care home or foster care group home

☐ Hospital or other residential non-psychiatric medical facility

☐ Jail, prison or juvenile detention facility

☐ Long-term care facility or nursing home

☐ Psychiatric hospital or other psychiatric facility

☐ Substance abuse treatment facility or detox center

Length of stay in institutional situation noted above

☐ One night or less

☐ Two to six nights

☐ One week or more, but less than one month

☐ One month or more, but less than 90 days

☐ 90 days or more, but less than one year

☐ One year or longer

☐ Client doesn't know

☐ 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")

☐ Residential project or halfway house with no homeless criteria

☐ Hotel or motel paid for without emergency shelter voucher

☐ Transitional housing for homeless persons (including homeless youth)

☐ Host home (non-crisis)

☐ Staying or living in a friend's room, apartment, or house

☐ Staying or living in a family member's room, apartment, or house

Length of stay in temporary situation noted above

☐ One night or less

☐ Two to six nights

☐ One week or more, but less than one month

☐ One month or more, but less than 90 days

☐ 90 days or more, but less than one year

☐ One year or longer

☐ Client doesn't know

☐ 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")

☐ Rental by client, no ongoing housing subsidy

☐ Rental by client, with ongoing subsidy (select subsidy type)

☐ Owned by client, with ongoing housing subsidy

☐ Owned by client, no ongoing housing subsidy

If "rental by client, with ongoing subsidy", select type

☐ GPD TIP housing subsidy

☐ VASH housing subsidy

☐ RRH or equivalent subsidy

☐ HCV Voucher (tenant or project based)

☐ Public housing unit

☐ Rental by client, with other ongoing housing subsidy

☐ Housing Stability Voucher

☐ Family Unification Program Voucher (FUP)

☐ Foster Youth to Independence Initiative (FYI)

☐ Permanent Supportive Housing

☐ Other permanent housing dedicated for formerly homeless persons

Length of stay in permanent situation noted above

☐ One night or less

☐ Two to six nights

☐ One week or more, but less than one month

☐ One month or more, but less than 90 days

☐ 90 days or more, but less than one year

☐ One year or longer

☐ Client doesn't know

☐ 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

Other

☐ Client doesn't know

☐ Client prefers not to answer

Skip to next section

Approximate date this episode of homelessness started: [December 1st of last year]

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

<input checked="" 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 [Please choose the number of months between the above December date and the entry date]

<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	

Sexual Orientation

Sexual Orientation	<input type="checkbox"/> Heterosexual	<input type="checkbox"/> Gay	<input type="checkbox"/> Lesbian	<input checked="" type="checkbox"/> Bisexual
	<input type="checkbox"/> Questioning/Unsure	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Other: _____

Health

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

Pregnancy Status ☐ No ☒ Yes ☐ Client doesn't know ☐ Client prefers not to answer

If yes, due date [4 months from the project entry]

Child Welfare/Foster Care Involvement

Formerly a Ward of Child Welfare or Foster Care Agency	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
If yes, number of years	<input checked="" type="checkbox"/> Less than one year	<input type="checkbox"/> 1 to 2 years	<input type="checkbox"/> 3 to 5 or more years	
If less than one year, number of months	<u>6</u> months (1-11)			

Juvenile Justice System Involvement

Formerly a Ward of Juvenile Justice System	<input checked="" 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	<input type="checkbox"/> Less than one year	<input type="checkbox"/> 1 to 2 years	<input type="checkbox"/> 3 to 5 or more years	
If less than one year, number of months	<u> </u> months (1-11)			

Translation Assistance [Head of Household Only]

Translation Assistance Needed?	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
If yes to "Translation Assistance Needed?", select preferred language:	<input type="checkbox"/> American Sign Language	<input type="checkbox"/> Arabic	<input type="checkbox"/> Bosnian	
	<input type="checkbox"/> Burmese	<input type="checkbox"/> Cantonese	<input type="checkbox"/> Chuukese	
	<input type="checkbox"/> Dinka	<input type="checkbox"/> Farsi	<input type="checkbox"/> French	
	<input type="checkbox"/> German	<input type="checkbox"/> Mandarin	<input type="checkbox"/> Romanian	
	<input type="checkbox"/> Russian	<input type="checkbox"/> Spanish	<input type="checkbox"/> Tagalog	
	<input type="checkbox"/> Tigrigna	<input type="checkbox"/> Ukrainian	<input type="checkbox"/> Urdu	
	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Different Preferred Language (specify): _____		
	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer		

Youth Education Status [Head of Household Only]

Current School Enrollment and Attendance	<input checked="" type="checkbox"/> Not currently enrolled in any school or educational course	<input type="checkbox"/> Client doesn't know	
		<input type="checkbox"/> Client prefers not to answer	
	<input type="checkbox"/> Currently enrolled but NOT attending regularly (when school or the course is in session)	<input type="checkbox"/> Data not collected	
	<input type="checkbox"/> Currently enrolled and attending regularly (when school or the course is in session)		
Most Recent Educational Status	<input type="checkbox"/> K12: Graduated from high school	<input type="checkbox"/> Higher education: pursuing a credential but not currently attending	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> K12: Obtained GED		<input type="checkbox"/> Client prefers not to answer
	<input checked="" type="checkbox"/> K12: Dropped out	<input type="checkbox"/> Higher Education: Dropped out	<input type="checkbox"/> Data not collected
	<input type="checkbox"/> K12: Suspended	<input type="checkbox"/> Higher Education: Obtained a credential/degree	
	<input type="checkbox"/> K12: Expelled		
Current Educational Status	<input type="checkbox"/> Pursuing a diploma or GED	<input type="checkbox"/> Client doesn't know	
	<input type="checkbox"/> Pursuing Associate's Degree	<input type="checkbox"/> Client prefers not to answer	
	<input type="checkbox"/> Pursuing Bachelor's Degree	<input type="checkbox"/> Data not collected	
	<input type="checkbox"/> Pursuing Graduate Degree		
	<input type="checkbox"/> Pursuing other post-secondary credential		

Disabilities

i	<p>If one or more of the options below with an asterisk(*) has been selected, the answer to "disabling condition" must be "yes."</p> <p>If none of the answers below with an asterisk(*) has been selected, the answer to "disabling condition" may be "yes" or "no."</p>
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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 checked="" 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 checked="" 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 checked="" 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 checked="" type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	(not applicable)			
Drug Use Disorder	<input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	(not applicable)			
Mental Health Disorder	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	<input checked="" type="checkbox"/> Yes*	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> PNTA
Physical Disability	<input type="checkbox"/> Yes <input checked="" 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	<p>"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.</p>
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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"/> From six to twelve months ago <input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Three to six months ago <input type="checkbox"/> More than a year ago <input type="checkbox"/> Client prefers not to answer
If yes, currently fleeing?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer

Confirm child's information in the RRH entry from TH intake.Staff: _____ Project Start Date: **[The 1st of two months ago]** Name of Head of Household: **Charlie [use your last name]**Project Name (Enter Data As): **[Use RRH project name provided in email as EDA]****Client Record**

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

Name **Jamie** **[use your last 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 **[make up a SSN]**

☒ 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 **03 / 01 / 2023**

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

Gender(s) **X** Woman (Girl, if child) ☐ Man (Boy, if child) ☐ Culturally Specific Identity (e.g. Two-Spirit)

select all that apply ☐ Transgender ☐ Non-Binary ☐ Questioning

☐ Different Identity (specify): _____ ☐ Client doesn't know ☐ Client prefers not to answer

Race(s) and Ethnicity ☐ American Indian, Alaska Native, or Indigenous **X** Asian or Asian American

select all that apply ☐ Black, African American, or African ☐ Hispanic/Latina/e/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 **X** 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 [mark the appropriate 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) [mark the County your client is residing in]

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 63114

☒ 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 [Rapid ReHousing projects only]

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 [leave blank until they receive a move in date]

Health Insurance

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

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

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 checked="" 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 checked="" 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 checked="" 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 checked="" type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> PNTA	(not applicable)			
Drug Use Disorder	<input type="checkbox"/> Yes	<input checked="" 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 checked="" type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> PNTA	(not applicable)			
Mental Health Disorder	<input type="checkbox"/> Yes	<input checked="" 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 checked="" 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

Your project provided one service at entry. Please record it on the clients' records using the information below.

Date of service: **The first of two months ago**

Service Needed: **Utility Arrearage Payment Plans**

Provider specific service: **Utility Arrears**

MHDC Payee: **ABC Utility Co.**

Monthly Rent Amount: **\$750**



Only answer if your project is funded by MHDC.

Funding Sources: ***Pick the correct funding source for your project.****

*If you are unsure what the correct funding source is for your project, please utilize the Funding Source tip sheet available here: <http://icamissouri.helpscoutdocs.com/article/116-funding-sources>

Amount: **\$1200**

Need Status: **Closed**

Outcome of Need: **Fully Met**