

**New Hampshire Continua of Care
SGIA Homelessness Prevention (HP) Project
Record Creation Intake Entry Services Exit Packet**

Fill out this form to determine if client is homeless or in need of services in order to prevent homelessness. In this packet, data is collected for:

- Client Universal Intake – to be signed by client and filed with the client’s record.
- The Homeless Management Information System (HMIS) – to be input into ServicePoint:
 - ✓ Client record Creation
 - ✓ Client Entry
 - ✓ Additional Supportive Services for client
 - ✓ Client Exit


The data collected on these forms should then be added to HMIS using the ServicePoint software within three (3) days of client intake.

The information on the following forms is taken from the HUD HMIS Data Standard documentation. Refer to the *2014 HMIS Data Standards Manual, Version 5.1* for an explanation of the data elements.

This SGIA HP Data Collection Packet can also be found on the NH-HMIS website at: www.nh-hmis.org.

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INTAKE DATA COLLECTION

 In ServicePoint, always set the Entry/Exit and services Type to "HUD".

Intake Interviewer Name: _____

Form Completed Date: _____

Case Manager Name: _____

ServicePoint Client ID: _____

Intake Questions

1. Marital Status

- | | |
|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Single | <input type="checkbox"/> Divorced |
| <input type="checkbox"/> Married | <input type="checkbox"/> Widowed |
| <input type="checkbox"/> Separated | |

2. Housing Status

Are you currently living in Subsidized Housing? Yes No

Have you applied for Section 8 or other Subsidized Housing? Yes No

If Yes, where and when? _____

Do you own your own home? Yes No

If Yes, are you facing foreclosure? Explain: _____

What barriers do you face that could prevent you from obtaining and keeping stable housing (please check all that apply)?

- | | | |
|--|---|--|
| <input type="checkbox"/> Finances | <input type="checkbox"/> Legal | <input type="checkbox"/> Unemployment |
| <input type="checkbox"/> Low-level education | <input type="checkbox"/> Lack of skills | <input type="checkbox"/> Poor rental history |
| <input type="checkbox"/> Mental health diagnosis | <input type="checkbox"/> History of substance abuse | <input type="checkbox"/> Other |

If "Other", please specify: _____

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3. Residence History (Please start with most recent.)						
Start and End Dates	Address w/ City, State & Zip	Housing Type	\$ Rent Amount	\$ Past Due Rent Amount?	\$ Past Due Utilities Amount?	Was Reason for Leaving Eviction?
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

Name of Current Landlord: _____
Address: _____
Phone Number: (____) _____ Fax: (____) _____

Name of Current Landlord: _____
Address: _____
Phone Number: (____) _____ Fax: (____) _____

4. Citizenship	
Are you a US Citizen?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If No, what is your current alien status?	<input type="checkbox"/> Lawfully qualified alien <input type="checkbox"/> Lawfully non-qualified alien <input type="checkbox"/> Undocumented alien

5. Transportation	
So you have a car?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a valid driver/s license?	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. Employment			
Employer/Address	Position	\$ Salary/Hr	Start/End Dates

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7. Assets (List value of all liquid assets as of date of application)			
Source of Asset (i.e., savings, stocks, etc.)	\$ Current Value	Less Withdrawal Penalty	Total Net Value
\$ Total Asset Value:		\$	

8. Monthly Expenses					
Expense	\$ Amount	Expense	\$ Amount	Expense	\$ Amount
Rent	\$	Food	\$	Childcare	\$
Phone	\$	Transportation	\$	Other	\$
Heat	\$	Electricity	\$	Other	\$
\$ Total Monthly Expenses:			\$		

9. Household Income	
Income as a percentage of AMI (Area Median Income):	
<input type="checkbox"/> Less than 30%	<input type="checkbox"/> 30% to 50%
<input type="checkbox"/> Greater than 50%	
<i>① Indicate household income limits as a percentage of area median income (AMI), as published annually on the HUD website at: http://www.huduser.org.</i>	

10. Education			
Are you currently in school? <input type="checkbox"/> Yes <input type="checkbox"/> No			
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	<input type="checkbox"/> School program has no grade levels	<input type="checkbox"/> GED	<input type="checkbox"/> Some college
<input type="checkbox"/> Associate's degree	<input type="checkbox"/> Bachelor's degree	<input type="checkbox"/> Vocational Cert.	
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused		
Are you now or have you been in a job training program? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, where and what type of program? _____			
Do you have difficulty with reading or writing? <input type="checkbox"/> Yes <input type="checkbox"/> No			

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11. Medical History
Do you or anyone in your household have any physical or mental health concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, please describe: _____

12. Emergency Contact Information
Emergency Contact: _____
Phone Number: _____

FALSE INFORMATION WILL RESULT IN DISMISSAL FROM THIS PROJECT

Client's Signature: _____ Date: ____/____/____

Staff Signature (witness): _____ Date: ____/____/____

❗ *After client and staff sign, this non-HMIS form should be filed with the client's record.*

<p>Choose which additional projects this client will be entered into:</p> <p><input type="checkbox"/> HUD CoC APR – Transitional Housing (TH), Permanent Housing (PH) and Emergency Shelter (ES)</p> <p><input type="checkbox"/> HUD ESG RRH – Re-housing</p> <p><input type="checkbox"/> HUD ESG HP – Homeless Prevention</p>
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<p>Depending on which project your client will be entered into, additional data must be collected as shown. These questions can be found later in this packet:</p> <p>1. If client is entering into CoC APR, TH, PH, ES programs, be sure to collect data on:</p> <p style="padding-left: 20px;">a. (Entry) First Time Homeless? (Page 11)</p> <p>2. If client is entering into an ESG RRH program, be sure to collect:</p> <p style="padding-left: 20px;">a. (Entry) In permanent housing? Residential move-in date? (Page 11)</p> <p style="padding-left: 20px;">b. (Entry) Is client homeless? (Page 11)</p> <p style="padding-left: 20px;">c. (Entry) First time homeless? (Page 11)</p>
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3. If client is entering into an ESG Homeless Prevention (HP) program, be sure to collect:
- a. (Entry) Is client chronically homeless? (Page 11)
 - b. (Exit) Housing assessment at exit. (Page 17)
 - c. (Exit) Subsidy information. (Page 17)
 - d. (Exit) If moved to new housing unit, subsidy information. (Page 17)

HMIS DATA COLLECTION INFORMATION

Prevention Project (client is at risk, but not homeless)

i In ServicePoint, always set the Entry/Exit and Services Type to "HUD".

Date Form Completed: ___/___/_____

Intake Interviewer's Name: _____

Case Manager's Name: _____

Project Name: _____

Client's ID: _____

Client's Project Entry Date: ___/___/_____

Location:

Choose appropriate HUD-assigned Coc Code:	<input type="checkbox"/> NH-500 (Balance of State/Concord) <input type="checkbox"/> NH-501 (Manchester) <input type="checkbox"/> NH-502 (Greater Nashua)
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Client Record Creation

First, MI, Last Name, Suffix: _____

Name Data Quality: Full name reported Partial, street name, or code name reported Client doesn't know Client refused

Alias: _____

Entry Date: ___/___/_____ Exit Date: ___/___/_____

SSN: _____

SSN Data Quality: Full SSN reported Partial SSN reported Client doesn't know or has no SSN Client refused Data not collected

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US Military Veteran? Yes No

If Yes to "US Military Veteran," has client ever **received health care benefits** from a VA Center? Yes
 No

Is client **receiving Veterans Services**? Yes No

Is client **eligible for Veterans Services**? Yes No

If No to "eligible for Veterans services," please select **Reason**:
 Client not interested Client doesn't know Data not collected

Please select **discharge type** for all persons who answered Yes to "US Military Veteran" and are not currently serving:

<input type="checkbox"/> Honorable	<input type="checkbox"/> General under honorable conditions	<input type="checkbox"/> Under other than honorable conditions (OTH)
<input type="checkbox"/> Bad Conduct	<input type="checkbox"/> Dishonorable	<input type="checkbox"/> Uncharacterized
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected

Date of Birth: ___/___/_____

Date of Birth type: Full DOB reported Partial or approximate DOB reported
 Client doesn't know Client refused Data not collected

Race: (Client may choose up to 5.)
 American Indian or Alaska Native Native Hawaiian or Other Pacific Islander
 Asian White Black or African American
 Client doesn't know Client refused Data not collected

Ethnicity: (Choose one.)
 Hispanic/Latino Non-Hispanic/Non-Latino
 Client doesn't know Client refused Data not collected

Gender:
 Female Male Transgender male to female
 Transgender female to male Does not identify as female, male or transgender
 Client doesn't know Client refused Data not collected

Entry Data

Section 1: Project Entry (in ServicePoint use Entry/Exit Tab)



Relationship to Head of Household (HoH): (Choose one.):
 Self Head of household's child Head of household's spouse or partner
 Head of household's other relation member (other relation to HoH)
 Other: non-relation member

Does client have a Disabling Condition?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
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Section 2: Disability Type

-  Answer the group of questions associated with each applicable disability type, using HUD verification.
-  This information should be collected for all clients, regardless of age.

Physical Disability

Date of information collection: ___/___/_____

Physical Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
If "Yes" to Physical Disability, expected to be of long-continued and indefinite duration and substantially impairs client's ability to live independently? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
If "Yes," to Physical Disability, is documentation of the disability and severity on file? <input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes" to Physical Disability, is client currently receiving services or treatment for this disability? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused

Developmental Disability

Date of information collection: ___/___/_____

Developmental Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
If "Yes" to Developmental Disability, is it expected to substantially impair client's ability to live independently? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
If "Yes," to Developmental Disability, is documentation of the disability and severity on file? <input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes," to Developmental Disability, is client currently receiving services or treatment for it? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused

Chronic Health Condition

Date of information collection: ___/___/_____

Chronic Health Condition? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
If "Yes," to Chronic Health Condition, is it expected to be of long-continued and indefinite duration and substantially impairs client's ability to live independently? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
If "Yes," to Chronic Health Condition, is documentation of the disability and severity on file? <input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes," to Chronic Health Condition, is client currently receiving services or treatment for it? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused

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HIV/AIDS

Date of information collection: ___/___/_____

HIV/AIDS?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Client refused		
If "Yes", to HIV/AIDS, is it expected to substantially impair client's ability to live independently?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Client refused		
If "Yes," to HIV/AIDS, is documentation of the disability and severity on file? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes," to HIV/AIDS, is client currently receiving services or treatment for it?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Client refused		

Mental Health Problem

Date of information collection: ___/___/_____

Mental Health Problem?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Client refused		
If "Yes", to Mental Health Problem, is it expected to be of long-continued and indefinite duration and substantially impairs client's ability to live independently?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Client refused		
If "Yes," to Mental Health Problem, is documentation of the disability and severity on file? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes," to Mental Health Problem, is client currently receiving services or treatment for it?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Client refused		

Substance Abuse

Date of information collection: ___/___/_____

Substance Abuse?		
<input type="checkbox"/> No	<input type="checkbox"/> Alcohol abuse	<input type="checkbox"/> Drug abuse
<input type="checkbox"/> Both alcohol and drug abuse	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
If "Yes", to Alcohol abuse, Drug abuse, or Both alcohol and drug abuse for "Substance Abuse," is it expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Client refused		
If "Yes," to Alcohol abuse, Drug abuse or Both alcohol and drug abuse for "Substance Abuse Problem," is documentation of the disability and severity on file? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes," to Alcohol abuse, Drug abuse, or Both alcohol and drug abuse for "Substance Abuse Problem," is client currently receiving services or treatment for it?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Client refused		

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Section 3: Health Insurance (In ServicePoint use Entry/Exit Tab)	
i <i>Complete for all household members.</i>	
Date of information collection: ___/___/_____ <input type="checkbox"/> Yes <input type="checkbox"/> No Covered by health insurance?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected	
MEDICAID	<input type="checkbox"/> Yes <input type="checkbox"/> No
MEDICARE	<input type="checkbox"/> Yes <input type="checkbox"/> No
State Children's Health Insurance Program	<input type="checkbox"/> Yes <input type="checkbox"/> No
Veteran's Administration (VA) Medical Services	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employer-provided health insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No
Health insurance obtained through COBRA	<input type="checkbox"/> Yes <input type="checkbox"/> No
Private pay health insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No
State Health Insurance for Adults	<input type="checkbox"/> Yes <input type="checkbox"/> No
Indian Health Services Program	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (Please specify below.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Other," please specify:	

Section 4: Living Situation: Residence Prior To Project Entry	
i <i>In this section you will need to consider the client's residence as of the day before project entry. Please answer the check boxes below, then follow the instructions to the appropriate sub-section.</i>	
On the day before project entry, was client living in:	
A place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside).	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Shelter, including hotel or motel paid for with emergency shelter voucher (HUD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Safe Haven	<input type="checkbox"/> Yes <input type="checkbox"/> No
Interim Housing	<input type="checkbox"/> Yes <input type="checkbox"/> No
i <i>If "Yes" to any of the above, please skip down to the Homeless Situation subsection and answer the questions there.</i>	
Foster care home or foster care group home (HUD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hospital or other residential non-psychiatric medical facility (HUD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Jail, prison or juvenile detention facility (HUD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Long-term care facility or nursing home (HUD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychiatric hospital or other psychiatric facility (HUD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Substance abuse treatment facility or detox center (HUD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
i <i>If "Yes" to any of the above, please skip down to the Institutional Situation Subsection and answer the questions there.</i>	
Hotel or motel paid for without emergency shelter voucher (HUD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Owned by client, no ongoing housing subsidy (HUD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Owned by client, with ongoing housing subsidy (HUD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Permanent housing for formerly homeless persons (HUD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rental by client, no ongoing housing subsidy (HUD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rental by client, with VASH subsidy (HUD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rental by client, with GPD TIP subsidy (HUD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rental by client, with other ongoing housing subsidy (HUD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Residential project or halfway house with no homeless criteria (HUD)	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Staying or living in a family member's room, apartment or house (HUD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Staying in a friend's room, apartment or house (HUD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Transitional housing for homeless persons (including homeless youth) (HUD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Client doesn't know (HUD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Client refused (HUD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Data not collected (HUD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
i <i>If "Yes" to any of the above, please skip down to the Transitional and Permanent Housing Situation Subsection and answer the questions there.</i>	

Homeless Situation Subsection	
Length of Stay in Previous Place?	
<input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more but less than one month <input type="checkbox"/> One month or more but less than 90 days <input type="checkbox"/> 90 days or more but less than one year	<input type="checkbox"/> One year or longer <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Client Location:	<input type="checkbox"/> Balance of State (NH-500)
Information collection date: ___/___/_____	<input type="checkbox"/> Manchester (NH-501)
Select HUD-assigned CoC code(s) that best apply:	<input type="checkbox"/> Nashua (NH-502)
What is the approximate date the current homeless situation began? ___/___/_____	
Regardless of where they stayed last night, number of times the client been homeless on the streets, in ES or SH in the past three years, including today?	
<input type="checkbox"/> One time <input type="checkbox"/> Two times <input type="checkbox"/> Three times <input type="checkbox"/> Four or more times <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected	
Total number of month homeless on the streets, in ES or SH in the past three years?	
i <i>If this is the first month, select 1.</i>	
<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> More than 12 <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected	

i *Once this subsection is completed, there are no further questions for you in **Living Situation: Residence Prior to Project Entry**. Please skip down to the next section.*

Institutional Situation Subsection	
Length of stay in previous place?	
<input type="checkbox"/> One night or less <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> 90 days or more but less than one year <input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Two to six nights <input type="checkbox"/> One month or more but less than 90 days <input type="checkbox"/> One year or longer <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
i <i>If length of stay in previous place is MORE than 90 days, client doesn't know, client refused or data not collected, then there are no further questions for you in Living Situation: Residence Prior to Project Entry. Please skip down to the next section.</i>	

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If length of stay in previous place is LESS than 90 days, please answer the following :

On the night before, did the client stay on the streets, in ES or SH? Yes No

i If No, then there are no further questions for you in **Living Situation: Residence Prior to Project Entry**. Please skip down to the next section.

- If Yes to “on the street, in ES or SH,” what is the approximate date homelessness started:

___/___/_____

- If Yes to “on the street, in ES or SH,” and regardless of where they stayed last night, what is the number of times the client has been on the streets, in ES or SH in the past three years including today?

- One time Two times Three times
 Four or more times Client doesn't know Client refused
 Data not collected

- If Yes to “on the street, in ES or SH,” what is the total number of months homeless on the street, in ES or SH in the past three years?

i If this is the first month, select 1.

- 1 2 3 4 5
 6 7 8 9 10
 11 12 More than 12 Client doesn't know Client refused
 Data not collected

i Once you have completed this subsection, there are no further questions for you in **Living Situation: Residence Prior to Project Entry**. Please skip to next section.

Transitional and Permanent Housing Situation Subsection

Length of Stay in Previous Place:

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

i If length of stay in previous place is more than 6 nights, client doesn't know, client refused or data not collected, there are no further questions for you in **Living Situation: Residence Prior to Project Entry**. Please skip to the next section.

If “length of stay in previous place” is less than seven nights, please answer the following:

On the night before, did you stay on the streets, ES or SH? Yes No

i If No, then there are no further questions for you in **Living Situation: Residence Prior to Project Entry**. Please skip to next section.

- If Yes to “on the street, in ES or SH,” what is the approximate date homelessness started:

___/___/_____

- If Yes to “on the street, in ES or SH,” and regardless of where they stayed last night, what is the number of times the client has been on the streets, in ES or SH in the past three years including today?

- One time Two times Three times
 Four or more times Client doesn't know Client refused
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- If Yes to “on the street, in ES or SH,” what is the total number of months homeless on the street, in ES or SH in the past three years?
 - ❶ If this is the first month, select 1.
 - 1 2 3 4 5
 6 7 8 9 10
 11 12 More than 12 Client doesn't know Client refused
 Data not collected

Section 5: Income and Sources (in ServicePoint use Entry/Exit Tab)

Monthly Cash Income

- ❶ Ask client whether they receive income from EACH source listed rather than asking them to state the sources of income they receive.
- ❶ Record income for HOH and adult household members.
- ❶ Updates are required for persons aging into adulthood. Income or Benefits received by a minor child should be assigned to the HOH.

Information collection date: ___/___/_____ Income from any source? If “Yes,” to “income from any source,” please check “No” or “Yes” for each income source in the list below, and add amount.	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client refused <input type="checkbox"/> Client doesn't know
Monthly Income (cash) Source:		Amount:
Earned Income (i.e., employment income)	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$ _____
Unemployment Insurance	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$ _____
Supplemental Security Income (SSI)	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$ _____
Social Security Disability Income (SSDI)	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$ _____
VA Service-Connected Disability Compensation	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$ _____
VA Non-Service-Connected Disability Compensation	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$ _____
Private disability insurance	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$ _____
Worker's compensation	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$ _____
TANF	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$ _____
Retirement Income from Social Security	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$ _____
Pension/retirement income from former job	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$ _____
Child support	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$ _____
Alimony or other spousal support	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$ _____
Other source (specify below)	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$ _____

If “other source,” please specify source:

Monthly Income Total: \$ _____

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Non-Cash Benefits		
Information collection date: ___/___/_____ Non-Cash Benefit from any source? If "Yes," to "non-cash benefit from any source," please check "No" or "Yes" for each income source in the list below, and add amount.	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client refused <input type="checkbox"/> Client doesn't know
Monthly Non-Cash Benefit Source:		Amount:
Supplemental Nutrition Assistance Program (SNAP)	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
TANF child care services	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
TANF transportation services	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
Other TANF-funded services	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
Section 8, public housing or other ongoing rental assistance	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
Temporary rental assistance	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
Other source (specify below)	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
If "other source," please specify source:		
Monthly Income Total: \$ _____		

Section 6: Domestic Violence		
Is client Victim/Survivor of domestic violence?		
<input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Data not collected
<input type="checkbox"/> No	<input type="checkbox"/> Client refused	
If Yes, when was most recent occurrence?		
<input type="checkbox"/> Within the past 3 months	<input type="checkbox"/> Client doesn't know	
<input type="checkbox"/> 3-6 months ago	<input type="checkbox"/> Client refused	
<input type="checkbox"/> 6-12 months ago	<input type="checkbox"/> Data not collected	
<input type="checkbox"/> More than 12 months ago		
Is client currently fleeing?		
<input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Data not collected
<input type="checkbox"/> No	<input type="checkbox"/> Client refused	

**New Hampshire Continua of Care
SGIA Homelessness Prevention (HP) Project
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Section 7: BHHS Required Information	
Housing Status:	
<p> <i>Housing status as of the day before project entry.</i></p>	
Homelessness and at-risk of homelessness status	
<input type="checkbox"/> Category 1 -- Homeless (lacks fixed, regular and adequate nighttime residence) <input type="checkbox"/> Category 2 -- At imminent risk of losing housing (will lose primary nighttime residence in 14 days) <input type="checkbox"/> Category 3 -- Homeless only under other federal statutes (unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition) <input type="checkbox"/> Category 4 -- Fleeing domestic violence (when client or household does NOT meet any other criteria but is homeless solely because they are fleeing domestic violence) <input type="checkbox"/> At-risk of homelessness (for clients being served by Homelessness Prevention or Coordinated Assessment projects)	
<input type="checkbox"/> Stably housed <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected	
Zip code of last permanent address: _____ <i>Where client last lived for 90 days or more.</i>	
Zip code data quality:	
<input type="checkbox"/> Full or partial <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	
Employment Status:	
Is the client employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
(If yes) what is their tenure of employment?	<input type="checkbox"/> Full time <input type="checkbox"/> Part time
Homelessness Status:	
Is client's homelessness chronic? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Section 8: For RRH Projects Only -- Additional Questions at Entry	
Residential Move in Date (for Rapid Rehousing clients only)	
Date of move-in: ___/___/_____	
Is client homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No	

New Hampshire Continua of Care SGIA Homelessness Prevention (HP) Project Record Creation Intake Entry Services Exit Packet

Section 9: Head of Household																			
<p>Is this person the head of a household? (Households can have only one HoH.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, please list other members of the household and their relationship to the head of household below.</p>																			
<p>Household member #1: (You must complete all information for each household member.) First Name: _____ MI: ____ Last Name: _____ SSN: _____ Client ID # (ServicePoint Assigned): _____ Relationship to head of household (HoH): (Choose one.)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;"><input type="checkbox"/> Wife</td> <td style="width: 25%;"><input type="checkbox"/> Daughter</td> <td style="width: 25%;"><input type="checkbox"/> Grandfather</td> <td style="width: 25%;"><input type="checkbox"/> Other Relative</td> </tr> <tr> <td><input type="checkbox"/> Husband</td> <td><input type="checkbox"/> Son</td> <td><input type="checkbox"/> Grandmother</td> <td><input type="checkbox"/> Other Non-Relative</td> </tr> <tr> <td><input type="checkbox"/> Mother</td> <td><input type="checkbox"/> Step-Daughter</td> <td><input type="checkbox"/> Granddaughter</td> <td><input type="checkbox"/> Significant Other</td> </tr> <tr> <td><input type="checkbox"/> Father</td> <td><input type="checkbox"/> Step-Son</td> <td><input type="checkbox"/> Grandson</td> <td><input type="checkbox"/> Unknown</td> </tr> </table>				<input type="checkbox"/> Wife	<input type="checkbox"/> Daughter	<input type="checkbox"/> Grandfather	<input type="checkbox"/> Other Relative	<input type="checkbox"/> Husband	<input type="checkbox"/> Son	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Other Non-Relative	<input type="checkbox"/> Mother	<input type="checkbox"/> Step-Daughter	<input type="checkbox"/> Granddaughter	<input type="checkbox"/> Significant Other	<input type="checkbox"/> Father	<input type="checkbox"/> Step-Son	<input type="checkbox"/> Grandson	<input type="checkbox"/> Unknown
<input type="checkbox"/> Wife	<input type="checkbox"/> Daughter	<input type="checkbox"/> Grandfather	<input type="checkbox"/> Other Relative																
<input type="checkbox"/> Husband	<input type="checkbox"/> Son	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Other Non-Relative																
<input type="checkbox"/> Mother	<input type="checkbox"/> Step-Daughter	<input type="checkbox"/> Granddaughter	<input type="checkbox"/> Significant Other																
<input type="checkbox"/> Father	<input type="checkbox"/> Step-Son	<input type="checkbox"/> Grandson	<input type="checkbox"/> Unknown																
<p>Household member #2: (You must complete all information for each household member.) First Name: _____ MI: ____ Last Name: _____ SSN: _____ Client ID # (ServicePoint Assigned): _____ Relationship to head of household (HoH): (Choose one.)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;"><input type="checkbox"/> Wife</td> <td style="width: 25%;"><input type="checkbox"/> Daughter</td> <td style="width: 25%;"><input type="checkbox"/> Grandfather</td> <td style="width: 25%;"><input type="checkbox"/> Other Relative</td> </tr> <tr> <td><input type="checkbox"/> Husband</td> <td><input type="checkbox"/> Son</td> <td><input type="checkbox"/> Grandmother</td> <td><input type="checkbox"/> Other Non-Relative</td> </tr> <tr> <td><input type="checkbox"/> Mother</td> <td><input type="checkbox"/> Step-Daughter</td> <td><input type="checkbox"/> Granddaughter</td> <td><input type="checkbox"/> Significant Other</td> </tr> <tr> <td><input type="checkbox"/> Father</td> <td><input type="checkbox"/> Step-Son</td> <td><input type="checkbox"/> Grandson</td> <td><input type="checkbox"/> Unknown</td> </tr> </table>				<input type="checkbox"/> Wife	<input type="checkbox"/> Daughter	<input type="checkbox"/> Grandfather	<input type="checkbox"/> Other Relative	<input type="checkbox"/> Husband	<input type="checkbox"/> Son	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Other Non-Relative	<input type="checkbox"/> Mother	<input type="checkbox"/> Step-Daughter	<input type="checkbox"/> Granddaughter	<input type="checkbox"/> Significant Other	<input type="checkbox"/> Father	<input type="checkbox"/> Step-Son	<input type="checkbox"/> Grandson	<input type="checkbox"/> Unknown
<input type="checkbox"/> Wife	<input type="checkbox"/> Daughter	<input type="checkbox"/> Grandfather	<input type="checkbox"/> Other Relative																
<input type="checkbox"/> Husband	<input type="checkbox"/> Son	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Other Non-Relative																
<input type="checkbox"/> Mother	<input type="checkbox"/> Step-Daughter	<input type="checkbox"/> Granddaughter	<input type="checkbox"/> Significant Other																
<input type="checkbox"/> Father	<input type="checkbox"/> Step-Son	<input type="checkbox"/> Grandson	<input type="checkbox"/> Unknown																
<p>Household member #3: (You must complete all information for each household member.) First Name: _____ MI: ____ Last Name: _____ SSN: _____ Client ID # (ServicePoint Assigned): _____ Relationship to head of household (HoH): (Choose one.)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;"><input type="checkbox"/> Wife</td> <td style="width: 25%;"><input type="checkbox"/> Daughter</td> <td style="width: 25%;"><input type="checkbox"/> Grandfather</td> <td style="width: 25%;"><input type="checkbox"/> Other Relative</td> </tr> <tr> <td><input type="checkbox"/> Husband</td> <td><input type="checkbox"/> Son</td> <td><input type="checkbox"/> Grandmother</td> <td><input type="checkbox"/> Other Non-Relative</td> </tr> <tr> <td><input type="checkbox"/> Mother</td> <td><input type="checkbox"/> Step-Daughter</td> <td><input type="checkbox"/> Granddaughter</td> <td><input type="checkbox"/> Significant Other</td> </tr> <tr> <td><input type="checkbox"/> Father</td> <td><input type="checkbox"/> Step-Son</td> <td><input type="checkbox"/> Grandson</td> <td><input type="checkbox"/> Unknown</td> </tr> </table>				<input type="checkbox"/> Wife	<input type="checkbox"/> Daughter	<input type="checkbox"/> Grandfather	<input type="checkbox"/> Other Relative	<input type="checkbox"/> Husband	<input type="checkbox"/> Son	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Other Non-Relative	<input type="checkbox"/> Mother	<input type="checkbox"/> Step-Daughter	<input type="checkbox"/> Granddaughter	<input type="checkbox"/> Significant Other	<input type="checkbox"/> Father	<input type="checkbox"/> Step-Son	<input type="checkbox"/> Grandson	<input type="checkbox"/> Unknown
<input type="checkbox"/> Wife	<input type="checkbox"/> Daughter	<input type="checkbox"/> Grandfather	<input type="checkbox"/> Other Relative																
<input type="checkbox"/> Husband	<input type="checkbox"/> Son	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Other Non-Relative																
<input type="checkbox"/> Mother	<input type="checkbox"/> Step-Daughter	<input type="checkbox"/> Granddaughter	<input type="checkbox"/> Significant Other																
<input type="checkbox"/> Father	<input type="checkbox"/> Step-Son	<input type="checkbox"/> Grandson	<input type="checkbox"/> Unknown																
<p>Household member #4: (You must complete all information for each household member.) First Name: _____ MI: ____ Last Name: _____ SSN: _____ Client ID # (ServicePoint Assigned): _____ Relationship to head of household (HoH): (Choose one.)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;"><input type="checkbox"/> Wife</td> <td style="width: 25%;"><input type="checkbox"/> Daughter</td> <td style="width: 25%;"><input type="checkbox"/> Grandfather</td> <td style="width: 25%;"><input type="checkbox"/> Other Relative</td> </tr> <tr> <td><input type="checkbox"/> Husband</td> <td><input type="checkbox"/> Son</td> <td><input type="checkbox"/> Grandmother</td> <td><input type="checkbox"/> Other Non-Relative</td> </tr> <tr> <td><input type="checkbox"/> Mother</td> <td><input type="checkbox"/> Step-Daughter</td> <td><input type="checkbox"/> Granddaughter</td> <td><input type="checkbox"/> Significant Other</td> </tr> <tr> <td><input type="checkbox"/> Father</td> <td><input type="checkbox"/> Step-Son</td> <td><input type="checkbox"/> Grandson</td> <td><input type="checkbox"/> Unknown</td> </tr> </table>				<input type="checkbox"/> Wife	<input type="checkbox"/> Daughter	<input type="checkbox"/> Grandfather	<input type="checkbox"/> Other Relative	<input type="checkbox"/> Husband	<input type="checkbox"/> Son	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Other Non-Relative	<input type="checkbox"/> Mother	<input type="checkbox"/> Step-Daughter	<input type="checkbox"/> Granddaughter	<input type="checkbox"/> Significant Other	<input type="checkbox"/> Father	<input type="checkbox"/> Step-Son	<input type="checkbox"/> Grandson	<input type="checkbox"/> Unknown
<input type="checkbox"/> Wife	<input type="checkbox"/> Daughter	<input type="checkbox"/> Grandfather	<input type="checkbox"/> Other Relative																
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<input type="checkbox"/> Mother	<input type="checkbox"/> Step-Daughter	<input type="checkbox"/> Granddaughter	<input type="checkbox"/> Significant Other																
<input type="checkbox"/> Father	<input type="checkbox"/> Step-Son	<input type="checkbox"/> Grandson	<input type="checkbox"/> Unknown																
<p>Household member #5: (You must complete all information for each household member.) First Name: _____ MI: ____ Last Name: _____ SSN: _____ Client ID # (ServicePoint Assigned): _____ Relationship to head of household (HoH): (Choose one.)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;"><input type="checkbox"/> Wife</td> <td style="width: 25%;"><input type="checkbox"/> Daughter</td> <td style="width: 25%;"><input type="checkbox"/> Grandfather</td> <td style="width: 25%;"><input type="checkbox"/> Other Relative</td> </tr> <tr> <td><input type="checkbox"/> Husband</td> <td><input type="checkbox"/> Son</td> <td><input type="checkbox"/> Grandmother</td> <td><input type="checkbox"/> Other Non-Relative</td> </tr> <tr> <td><input type="checkbox"/> Mother</td> <td><input type="checkbox"/> Step-Daughter</td> <td><input type="checkbox"/> Granddaughter</td> <td><input type="checkbox"/> Significant Other</td> </tr> <tr> <td><input type="checkbox"/> Father</td> <td><input type="checkbox"/> Step-Son</td> <td><input type="checkbox"/> Grandson</td> <td><input type="checkbox"/> Unknown</td> </tr> </table>				<input type="checkbox"/> Wife	<input type="checkbox"/> Daughter	<input type="checkbox"/> Grandfather	<input type="checkbox"/> Other Relative	<input type="checkbox"/> Husband	<input type="checkbox"/> Son	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Other Non-Relative	<input type="checkbox"/> Mother	<input type="checkbox"/> Step-Daughter	<input type="checkbox"/> Granddaughter	<input type="checkbox"/> Significant Other	<input type="checkbox"/> Father	<input type="checkbox"/> Step-Son	<input type="checkbox"/> Grandson	<input type="checkbox"/> Unknown
<input type="checkbox"/> Wife	<input type="checkbox"/> Daughter	<input type="checkbox"/> Grandfather	<input type="checkbox"/> Other Relative																
<input type="checkbox"/> Husband	<input type="checkbox"/> Son	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Other Non-Relative																
<input type="checkbox"/> Mother	<input type="checkbox"/> Step-Daughter	<input type="checkbox"/> Granddaughter	<input type="checkbox"/> Significant Other																
<input type="checkbox"/> Father	<input type="checkbox"/> Step-Son	<input type="checkbox"/> Grandson	<input type="checkbox"/> Unknown																

New Hampshire Continua of Care SGIA Homelessness Prevention (HP) Project Record Creation Intake Entry Services Exit Packet

Additional Supportive Services Provided

Record the start and end dates of the services provided. Where applicable, please include the dollar amount. Collect and enter this information when services are provided as a one-time transaction and at least once every three months for projects that provide on-going services for consecutive months. Ensure that the dates you're providing do not start prior to the official "entry" date into HMIS; entry start date should always coincide with the start of financial assistance.

This data will be input to HMIS. If you need additional forms in order to add services for a client after initial intake, they can be found on the HMIS website at: www.nh-hmis.org.

When adding services information into ServicePoint, it is important to use the correct funding source based on the project type (HPRP has been retired):

- SGIA=SGIA Homeless Prevention

Project Name: _____ Date: _____			
Interviewer Name: _____			
Client Name: _____ ServicePoint ID #: _____			
Service	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)	Amount
Rental payment (includes rental arrears)			\$
Rental deposit (security deposit)			\$
Housing search (includes rental application and costs for housing inspection)			\$
Moving expense			\$
Utility deposit			\$
Utility service payment			\$
Credit counseling			\$
Case/care management			\$
Transportation (only for ESG prevention)			\$
Total SGIA amount:			\$

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i When a client exits, be sure to enter the end date and change the status to "Closed," in ServicePoint. Also, edit the outcome of the need related to the service at this time.

Exit Data

Section 1: Reason for Leaving & Destination at Exit (in ServicePoint use Entry/Exit Tab)

i Record services that have been provided as of the project exit date.

Reason for leaving (choose one):	
<input type="checkbox"/> Completed Program	<input type="checkbox"/> Disagreement with rules/persons
<input type="checkbox"/> Criminal activity/violence	<input type="checkbox"/> Housing opportunity before completing
<input type="checkbox"/> Death	<input type="checkbox"/> Needs could not be met
<input type="checkbox"/> Non-compliance with program	<input type="checkbox"/> Non-payment of rent
<input type="checkbox"/> Reached maximum time allowed	<input type="checkbox"/> Unknown/disappeared
	<input type="checkbox"/> Other (Please specify:)
Destination (choose one):	
<input type="checkbox"/> Deceased	<input type="checkbox"/> Rental by client, no ongoing housing subsidy
<input type="checkbox"/> Emergency shelter, including hotel or motel paid with emergency shelter voucher	<input type="checkbox"/> Rental by client, with VASH subsidy
<input type="checkbox"/> Foster care home or foster care group home	<input type="checkbox"/> Rental by client, with GPD TIP subsidy
<input type="checkbox"/> Hospital or other residential non-psychiatric medical facility)	<input type="checkbox"/> Rental by client, with other ongoing housing subsidy
<input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher	<input type="checkbox"/> Residential project or halfway house with no homeless criteria
<input type="checkbox"/> Jail, prison or juvenile detention facility	<input type="checkbox"/> Safe Haven
<input type="checkbox"/> Long-term care facility or nursing home	<input type="checkbox"/> Staying or living with family, permanent tenure
<input type="checkbox"/> Moved from one HOPWA funded project to HOPWA - PH	<input type="checkbox"/> Staying or living with family, temporary tenure (e.g., room, apartment or house)
<input type="checkbox"/> Moved from one HOPWA funded project to HOPWA - TH	<input type="checkbox"/> Staying or living with friends, permanent tenure
<input type="checkbox"/> Owned by client, no ongoing housing subsidy	<input type="checkbox"/> Staying or living with friends, temporary tenure (e.g., room, apartment or house)
<input type="checkbox"/> Owned by client, with ongoing housing subsidy	<input type="checkbox"/> Substance abuse treatment facility or detox center
<input type="checkbox"/> Permanent housing for formerly homeless persons (such as: CoC project; HUD legacy programs, or HOPWA PH)	<input type="checkbox"/> Transitional housing for homeless persons (including youth)
<input type="checkbox"/> Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Psychiatric hospital or other psychiatric facility	<input type="checkbox"/> Client refused
	<input type="checkbox"/> No exit interview completed
	<input type="checkbox"/> Other (Please specify:)

Section 2: Health Insurance at Exit (in ServicePoint use Exit Tab)

i Update if information changed at exit.

Date of information collection: ____/____/____	
Covered by health insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	
<input type="checkbox"/> Data not collected	
MEDICAID	<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

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Veteran's Administration (VA) Medical Services	<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 (Please specify below.)	<input type="checkbox"/> No <input type="checkbox"/> Yes
If "other," please specify:	

Section 3: Disability Type at Exit (in ServicePoint use Entry/Exit Tab)

- i Update if information changed at exit.
- i Answer the group of questions associated with each applicable disability type, using HUD verification. This information should be collected for all clients, regardless of age.

Physical Disability

Date of information collection: ___/___/_____

Physical Disability?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Client refused		
If "Yes" to Physical Disability, expected to be of long-continued and indefinite duration and substantially impairs client's ability to live independently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Client refused		
If "Yes," to Physical Disability, is documentation of the disability and severity on file?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If "Yes" to Physical Disability, is client currently receiving services or treatment for this disability?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Client refused		

Developmental Disability

Date of information collection: ___/___/_____

Developmental Disability?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Client refused		
If "Yes" to Developmental Disability, is it expected to substantially impair client's ability to live independently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Client refused		
If "Yes," to Developmental Disability, is documentation of the disability and severity on file?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If "Yes," to Developmental Disability, is client currently receiving services or treatment for it?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Client refused		

Chronic Health Condition

Date of information collection: ___/___/_____

Chronic Health Condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Client refused		

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<p>If “Yes,” to Chronic Health Condition, is it expected to be of long-continued and indefinite duration and substantially impairs client’s ability to live independently?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn’t know <input type="checkbox"/> Client refused</p>
<p>If “Yes,” to Chronic Health Condition, is documentation of the disability and severity on file? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>If “Yes,” to Chronic Health Condition, is client currently receiving services or treatment for it?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn’t know <input type="checkbox"/> Client refused</p>

HIV/AIDS

Date of information collection: ___/___/_____

<p>HIV/AIDS?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn’t know <input type="checkbox"/> Client refused</p>
<p>If “Yes,” to HIV/AIDS, is it expected to substantially impair client’s ability to live independently?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn’t know <input type="checkbox"/> Client refused</p>
<p>If “Yes,” to HIV/AIDS, is documentation of the disability and severity on file? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>If “Yes,” to HIV/AIDS, is client currently receiving services or treatment for it?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn’t know <input type="checkbox"/> Client refused</p>

Mental Health Problem

Date of information collection: ___/___/_____

<p>Mental Health Problem?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn’t know <input type="checkbox"/> Client refused</p>
<p>If “Yes,” to Mental Health Problem, is it expected to be of long-continued and indefinite duration and substantially impairs client’s ability to live independently?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn’t know <input type="checkbox"/> Client refused</p>
<p>If “Yes,” to Mental Health Problem, is documentation of the disability and severity on file? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>If “Yes,” to Mental Health Problem, is client currently receiving services or treatment for it?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn’t know <input type="checkbox"/> Client refused</p>

Substance Abuse

Date of information collection: ___/___/_____

<p>Substance Abuse?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Drug abuse <input type="checkbox"/> Both alcohol and drug abuse <input type="checkbox"/> Client doesn’t know <input type="checkbox"/> Client refused</p>
<p>If “Yes,” to Alcohol abuse, Drug abuse, or Both alcohol and drug abuse for “Substance Abuse,” is it expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn’t know <input type="checkbox"/> Client refused</p>
<p>If “Yes,” to Alcohol abuse, Drug abuse or Both alcohol and drug abuse for “Substance Abuse Problem,” is documentation of the disability and severity on file? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>If “Yes,” to Alcohol abuse, Drug abuse, or Both alcohol and drug abuse for “Substance Abuse Problem,” is client currently receiving services or treatment for it?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn’t know <input type="checkbox"/> Client refused</p>

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Section 4: Income at Exit (in ServicePoint use Entry/Exit Tab)

- i** Ask client whether they receive income from EACH source listed rather than asking them to state the sources of income they receive.

Cash Income		
Date of information collection: ____/____/____		
Income from any source?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected	
If Yes, please fill in section below.		
Monthly Income (cash) Source:		Amount:
Earned Income (i.e., employment income)	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
Unemployment Insurance	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
Supplemental Security Income (SSI)	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
Social Security Disability Income (SSDI)	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
VA Service-Connected Disability Compensation	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
VA Non-Service-Connected Disability Compensation	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
Private disability insurance	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
Worker's compensation	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
TANF	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
Retirement Income from Social Security	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
Pension/retirement income from former job	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
Child support	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
Alimony or other spousal support	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
Other source (specify below)	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
If <i>Other</i> , please specify:		
Monthly Income Total: \$ _____		

Non-Cash Benefits		
Date of information collection: ____/____/____		
Non-Cash Benefit from any source?		
	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client refused <input type="checkbox"/> Client doesn't know
If Yes, please fill in section below.		
Monthly Non-Cash Benefit Source:		Amount:
Supplemental Nutrition Assistance Program (SNAP)	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
TANF child care services	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
TANF transportation services	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
Other TANF-funded services	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
Section 8, public housing or other ongoing rental assistance	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
Temporary rental assistance	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$
Other source (Please specify below.)	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$

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SGIA Homelessness Prevention (HP) Project
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If "Other source," please specify here:
Monthly Income Total \$ _____

Section 6: BHHS Required Information

Housing Status:

Housing status as of the day before project entry.

Homelessness and at-risk of homelessness status

- Category 1** -- Homeless (lacks fixed, regular and adequate nighttime residence)
 - Category 2** -- At imminent risk of losing housing (will lose primary nighttime residence in 14 days)
 - Category 3** -- Homeless only under other federal statutes (unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition)
 - Category 4** -- Fleeing domestic violence (when client or household does NOT meet any other criteria but is homeless solely because they are fleeing domestic violence)
 - At-risk of homelessness** (for clients being served by Homelessness Prevention or Coordinated Assessment projects)
- Stably housed**
 Client doesn't know
 Client refused
 Data not collected

Zip code of last permanent address: _____
Where client last lived for 90 days or more.

Zip code data quality:

- Full or partial
 Client doesn't know
 Client refused

Employment Status:

Is the client employed?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
(If Yes,) what is their tenure of employment?	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time

Homelessness Status:

Is client's homelessness chronic? Yes No

Client Location:

Information collection date: ____/____/____	
Select the HUD-assigned CoC code(s) that best apply:	<input type="checkbox"/> Balance of State (NH-500) <input type="checkbox"/> Manchester (NH-501) <input type="checkbox"/> Greater Nashua (NH-502)

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Section 7: Housing Assessment at Exit – SGIA and ESG Prevention Projects Only
(In ServicePoint use Exit Tab.)

- i *Assessment of head of household’s critical housing needs at exit.*
- i *“Moved into a transitional or temporary housing facility or program” includes transitional housing for homeless and non-homeless persons, treatment facilities, or institutions.*

Assessment (choose one):	
<input type="checkbox"/> Able to maintain the housing they had at project entry <input type="checkbox"/> Moved to new housing unit <input type="checkbox"/> Moved in with family/friends on a temporary basis) <input type="checkbox"/> Moved in with family/friends on a permanent basis <input type="checkbox"/> Moved to a transitional or temporary housing facility or program	<input type="checkbox"/> Client became homeless – moving to a shelter or other place unfit for human habitation <input type="checkbox"/> Client went to jail/prison <input type="checkbox"/> Client died <input type="checkbox"/> Client doesn’t know <input type="checkbox"/> Client refused
Subsidy Information (if able to maintain the housing they had at project entry, choose one):	
<input type="checkbox"/> Without a subsidy <input type="checkbox"/> With the subsidy they had at project entry	<input type="checkbox"/> With an on-going subsidy acquired since project entry <input type="checkbox"/> Only with financial assistance other than a subsidy
Subsidy Information (if moved to new housing unit, choose one):	
<input type="checkbox"/> With an ongoing subsidy	<input type="checkbox"/> Without an ongoing subsidy
Important last steps:	
Is this person part of a household? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes:	
<ol style="list-style-type: none"> 1. Complete an EXIT form for each family member. 2. Make sure to end any services the client has received while in the program by entering an end date for each service on the Supportive Services form. 	

This form can be found on the HMIS website at: www.nh-hmis.org.