

New Hampshire Continua of Care Universal and Common Data Collection Entry/Update/Annual Assessment Form

HMIS UNIVERSAL DATA ELEMENTS

- ✓ Please fill out for EACH household member at **entry**.
- ✓ ALL members 18 years of age and over must also sign the consent form for HMIS.

| Record Identifiers | |
|---------------------------------|--|
| ServicePoint Client ID#: | |
| Head of Household Name: | |
| Date: | |
| Case Manager Name: | |

3.1-3.20: Client Record Creation

✓ *To be collected for all clients at entry into a HMIS project.*

| | | | | | | | | | |
|--|---|--------|--|---------|--|-------|--|---------|--|
| Name | <table style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 50%; padding: 2px;">First:</td><td style="padding: 2px;"></td></tr> <tr><td style="padding: 2px;">Middle:</td><td style="padding: 2px;"></td></tr> <tr><td style="padding: 2px;">Last:</td><td style="padding: 2px;"></td></tr> <tr><td style="padding: 2px;">Suffix:</td><td style="padding: 2px;"></td></tr> </table> | First: | | Middle: | | Last: | | Suffix: | |
| First: | | | | | | | | | |
| Middle: | | | | | | | | | |
| Last: | | | | | | | | | |
| Suffix: | | | | | | | | | |
| Name Data Quality | <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Partial, street name or code name reported <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected | | | | | | | | |
| Alias | | | | | | | | | |
| Social Security Number | ___/___/_____ | | | | | | | | |
| SSN Data Quality | <input type="checkbox"/> Full SSN reported <input type="checkbox"/> Approximate or partial SSN reported <input type="checkbox"/> Client refused <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Data not collected | | | | | | | | |
| Date of Birth | | | | | | | | | |
| Date of Birth Type | <input type="checkbox"/> Full DOB reported <input type="checkbox"/> Approximate or Partial DOB reported <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected | | | | | | | | |
| Race (choose as many as are applicable) | <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected | | | | | | | | |
| Ethnicity | <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected | | | | | | | | |
| Gender | <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Trans Female (MTF or Male to Female) <input type="checkbox"/> Trans Male (FTM or Female to Male) <input type="checkbox"/> Gender Non-Conforming (i.e. not exclusively male or female) <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected | | | | | | | | |
| U.S. Military Veteran? | <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 | | | | | | | | |
| If Yes to "US Military Veteran" | Has client ever received health care benefits from a VA Center? <input type="checkbox"/> No <input type="checkbox"/> Yes Is client receiving Veterans Services ? <input type="checkbox"/> No <input type="checkbox"/> Yes Is client eligible for Veterans Services ? <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | | | |
| If No to "eligible for Veterans Services," please select reason. | <input type="checkbox"/> Client not eligible due to discharge status <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> 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 | | | | | | | | |
| Disabling Condition? | <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 | | | | | | | | |
| Project Start Date: | ___/___/_____ | | | | | | | | |

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| | |
|---|--|
| Personal ID: | |
| Household ID: | |
| Relationship to Head of Household: | <input type="checkbox"/> Self <input type="checkbox"/> Head of household's child <input type="checkbox"/> Head of household's spouse or partner <input type="checkbox"/> Head of household's other relation member (other relation to HoH) <input type="checkbox"/> Other: non-relation member |
| Client Location: | <input type="checkbox"/> BOS (NH-500) <input type="checkbox"/> MCOC (NH-501) <input type="checkbox"/> GNCOC (NH-502) |
| Client Location Information Date: | ___/___/___ |
| Housing Move-In Date: (all PH including PH-RRH only) | ___/___/___ |
| Living Situation: | <p>i Please fill out either supplemental form <i>LIVING SITUATION 3.917A: Street Outreach, Emergency Shelter & Safe Haven</i>, or supplemental form <i>LIVING SITUATION 3.917B: For Persons Entering Transitional Housing, any type of Permanent Housing, Services Only, Day Shelter, Homelessness Prevention, or any Coordinated Entry Project</i> to complete this field.</p> |

HMIS COMMON DATA ELEMENTS

| | | |
|---|--|------------------------|
| 4.2: Income and Sources | | |
| <p>✓ <i>To be collected for at project entry, update, and annual assessment.</i></p> <p>i Ask client whether they receive income from EACH source listed rather than asking them to state the sources of income they receive.</p> <p>i Income or Benefits received by a minor child should be assigned to the HOH.</p> <p>i Updates are required for persons aging into adulthood.</p> | | |
| Date of information collection: ___/___/___ | | |
| Income from any source? <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 <i>If Yes for "Income from any source," indicate all sources and dollar amounts for the source that apply.</i> | | |
| Monthly Income (cash) Source: | | Monthly 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 | \$ |
| Temporary Assistance for Needy Families (TANF) | <input type="checkbox"/> No <input type="checkbox"/> Yes | \$ |
| General Assistance (GA) | <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 Yes for "other source," please specify: | | |
| Monthly Income Total: | | \$ _____ .00 |

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4.3: Non-Cash Benefits

- ✓ *To be collected at entry, update, and annual assessment.*
- ❗ Ask client whether they receive income from each source listed rather than asking them to state the sources of income they receive.

Date of information collection: ___/___/_____

Non-Cash Benefit from any source?

- No Yes Client doesn't know Client refused Data not collected

If Yes for Non-cash benefits from any source, please indicate all sources and dollar amounts that apply.

| Non-Cash Benefit Source | | Amount |
|---|--|--------|
| <input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP/Food Stamps) | <input type="checkbox"/> No <input type="checkbox"/> Yes | \$ |
| <input type="checkbox"/> Special Supplemental Nutrition Program (WIC) | <input type="checkbox"/> No <input type="checkbox"/> Yes | \$ |
| <input type="checkbox"/> TANF Child Care services | <input type="checkbox"/> No <input type="checkbox"/> Yes | \$ |
| <input type="checkbox"/> TANF Transportation services | <input type="checkbox"/> No <input type="checkbox"/> Yes | \$ |
| <input type="checkbox"/> Other TANF-funded services | <input type="checkbox"/> No <input type="checkbox"/> Yes | \$ |
| <input type="checkbox"/> Other Source (specify below) | <input type="checkbox"/> No <input type="checkbox"/> Yes | \$ |

If Yes for "other source," please specify:

Monthly non-cash benefits total: \$_____.00

4.4: Health Insurance

- ✓ *To be collected at entry, update, and annual assessment for all clients, regardless of age.*

Date of information collection: ___/___/_____

Covered by health insurance?

- No Yes Client doesn't know Client refused Data not collected

If Yes for "Covered by health insurance," please indicate all sources of coverage below.

| Health Insurance Source | Covered? | If not covered, reason? (HOPWA only.) |
|--|--|--|
| MEDICAID | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Applied, decision pending <input type="checkbox"/> Applied, client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client <input type="checkbox"/> Client Doesn't know <input type="checkbox"/> Client Refused |
| MEDICARE | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Applied, decision pending <input type="checkbox"/> Applied, client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client <input type="checkbox"/> Client Doesn't know <input type="checkbox"/> Client Refused |
| State Children's Health Insurance Program | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Applied, decision pending <input type="checkbox"/> Applied, client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client <input type="checkbox"/> Client Doesn't know <input type="checkbox"/> Client Refused |

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| | | |
|---|--|--|
| Veteran's Administration (VA) Medical Services | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Applied, decision pending <input type="checkbox"/> Applied, client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client <input type="checkbox"/> Client Doesn't know <input type="checkbox"/> Client Refused |
| Employer-Provided Health Insurance | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Applied, decision pending <input type="checkbox"/> Applied, client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client <input type="checkbox"/> Client Doesn't know <input type="checkbox"/> Client Refused |
| Health Insurance Obtained Through COBRA | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Applied, decision pending <input type="checkbox"/> Applied, client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client <input type="checkbox"/> Client Doesn't know <input type="checkbox"/> Client Refused |
| Private Pay Health Insurance (Please specify here.) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Applied, decision pending <input type="checkbox"/> Applied, client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client <input type="checkbox"/> Client Doesn't know <input type="checkbox"/> Client Refused |
| State Health Insurance for Adults | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Applied, decision pending <input type="checkbox"/> Applied, client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client <input type="checkbox"/> Client Doesn't know <input type="checkbox"/> Client Refused |
| Indian Health Services Program | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Applied, decision pending <input type="checkbox"/> Applied, client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client <input type="checkbox"/> Client Doesn't know <input type="checkbox"/> Client Refused |
| Other (Please specify here.) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Applied, decision pending <input type="checkbox"/> Applied, client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client <input type="checkbox"/> Client Doesn't know <input type="checkbox"/> Client Refused |

| | |
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| 4.5: Physical Disability | |
| <i>✓ To be collected at entry and update.</i> | |
| Information Date: | |
| Physical Disability? | <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 for physical disability) 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 <input type="checkbox"/> Data not collected |

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| 4.6: Developmental Disability | |
| ✓ <i>To be collected at entry and update.</i> | |
| Information Date: | |
| Developmental Disability? | <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 for developmental disability) is it expected to substantially impair ability to live independently? | <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 |

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|--|--|
| 4.7: Chronic Health Condition | |
| ✓ <i>To be collected at entry and update.</i> | |
| Information Date: | |
| Chronic Health Condition? | <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 for chronic health condition) 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 <input type="checkbox"/> Data not collected |

| | |
|--|--|
| 4.8: HIV/AIDS | |
| ✓ <i>To be collected at entry and update.</i> | |
| Information Date: | |
| HIV/AIDS? | <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 for HIV/AIDS) is it expected to substantially impair ability to live independently? | <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 |

| | |
|--|--|
| 4.9: Mental Health Problem | |
| ✓ <i>To be collected at entry and update.</i> | |
| Information Date: | |
| Mental Health Problem? | <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 for mental health problem) is it expected to be of long-continued and indefinite duration and substantially impair ability to live independently? | <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 |

| | |
|--|---|
| 4.10: Substance Abuse | |
| ✓ <i>To be collected at entry and update.</i> | |
| Information Date: | |
| Substance Abuse Problem? | <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 <input type="checkbox"/> Data not collected |
| (If alcohol abuse, drug abuse, or both alcohol and drug abuse for substance abuse problem) is it expected to be of long-continued and indefinite duration and substantially impair ability to live independently? | <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 |

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| | |
|---|---|
| 4.11: Domestic Violence | |
| ✓ <i>To be collected at project start and update.</i> | |
| Information Date: | |
| Domestic Violence Victim/Survivor? | <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 |
| (If Yes) when experience occurred: | <input type="checkbox"/> Within past 3 months <input type="checkbox"/> 3-6 months ago <input type="checkbox"/> 6 months to one year ago <input type="checkbox"/> One year ago or more <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected |
| (If Yes) are you currently fleeing? | <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 |

| | |
|--|--|
| 4.12: Contact | |
| ✓ <i>To be collected at time of contact by CE-HOIP, PATH, and RHY-SO only.</i> | |
| Information Date (date of contact): | |
| Staying on Streets, ES, or SH: | <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Worker unable to determine |

| | |
|---|--|
| 4.13: Date of Engagement | |
| ✓ <i>To be collected at point of engagement by CE-HOIP, PATH, and RHY-SO only..</i> | |
| Date of Engagement: | |

| | |
|--|--|
| BHHS Required Information | |
| ✓ <i>To be collected at entry, update and annual assessment.</i> | |
| Homelessness and at-risk of homelessness status (as of the day before project entry): | <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 (of 90 days or more): | |
| Zip Code quality: | <input type="checkbox"/> Full or Partial <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected |
| Is the client employed? | <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) what is their type of employment? | <input type="checkbox"/> Full time <input type="checkbox"/> Part time |
| 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) |