

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	
✓ <i>To be collected for all clients at entry into a HMIS project.</i>	

Name	<table style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 80%; 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

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

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)