

## 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	
<b>ServicePoint Client ID#:</b>	
<b>Head of Household Name:</b>	
<b>Date:</b>	
<b>Case Manager Name:</b>	

3.1-3.20: Client Record Creation	
✓ <i>To be collected for all clients at entry into a HMIS project.</i>	

<b>Name</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="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:									
<b>Name Data Quality</b>	<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								
<b>Alias</b>									
<b>Social Security Number</b>	___/___/_____								
<b>SSN Data Quality</b>	<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								
<b>Date of Birth</b>									
<b>Date of Birth Type</b>	<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								
<b>Race (choose as many as are applicable)</b>	<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								
<b>Ethnicity</b>	<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								
<b>Gender</b>	<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								
<b>U.S. Military Veteran?</b>	<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								
<b>If Yes to "US Military Veteran"</b>	Has client ever <b>received health care benefits</b> from a VA Center? <input type="checkbox"/> No <input type="checkbox"/> Yes Is client <b>receiving Veterans Services</b> ? <input type="checkbox"/> No <input type="checkbox"/> Yes Is client <b>eligible for Veterans Services</b> ? <input type="checkbox"/> No <input type="checkbox"/> Yes								
<b>If No to "eligible for Veterans Services," please select reason.</b>	<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								
<b>Please select discharge type for all persons who answered YES to "US Military Veteran" and are not currently serving:</b>	<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								
<b>Disabling Condition?</b>	<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								
<b>Project Start Date:</b>	___/___/_____								

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<b>Personal ID:</b>	
<b>Household ID:</b>	
<b>Relationship to Head of Household:</b>	<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
<b>Client Location:</b>	<input type="checkbox"/> BOS (NH-500) <input type="checkbox"/> MCOC (NH-501) <input type="checkbox"/> GNCOC (NH-502)
<b>Client Location Information Date:</b>	___/___/___
<b>Housing Move-In Date:</b> (all PH including PH-RRH only)	___/___/___
<b>Living Situation:</b>	<p><b>i</b> Please fill out either supplemental form <i>LIVING SITUATION 3.917A: Street Outreach, Emergency Shelter &amp; 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**

<b>4.2: Income and Sources</b>		
<p>✓ <i>To be collected for at project entry, update, and annual assessment.</i></p> <p><b>i</b> Ask client whether they receive income from EACH source listed rather than asking them to state the sources of income they receive.</p> <p><b>i</b> Income or Benefits received by a minor child should be assigned to the HOH.</p> <p><b>i</b> Updates are required for persons aging into adulthood.</p>		
<p><b>Date of information collection:</b> ___/___/___</p> <p><b>Income from any source?</b>   <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</p> <p><i>If Yes for "Income from any source," indicate all sources and dollar amounts for the source that apply.</i></p>		
<b>Monthly Income (cash) Source:</b>		<b>Monthly Amount:</b>
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	\$
<b>If Yes for "other source," please specify:</b>		
<b>Monthly Income Total:</b>		\$ _____ .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: \$\_\_\_\_\_.

### 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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<b>Veteran's Administration (VA) Medical Services</b>	<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
<b>Employer-Provided Health Insurance</b>	<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
<b>Health Insurance Obtained Through COBRA</b>	<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
<b>Private Pay Health Insurance</b> (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
<b>State Health Insurance for Adults</b>	<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
<b>Indian Health Services Program</b>	<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
<b>Other</b> (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

<b>4.5: Physical Disability</b>	
<i>✓ To be collected at entry and update.</i>	
<b>Information Date:</b>	
<b>Physical Disability?</b>	<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
<b>(If Yes for physical disability) is it expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?</b>	<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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<b>4.6: Developmental Disability</b>	
✓ <i>To be collected at entry and update.</i>	
<b>Information Date:</b>	
<b>Developmental Disability?</b>	<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) <b>is it expected to substantially impair ability to live independently?</b>	<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

<b>4.7: Chronic Health Condition</b>	
✓ <i>To be collected at entry and update.</i>	
<b>Information Date:</b>	
<b>Chronic Health Condition?</b>	<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) <b>is it expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?</b>	<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

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

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

<b>4.10: Substance Abuse</b>	
✓ <i>To be collected at entry and update.</i>	
<b>Information Date:</b>	
<b>Substance Abuse Problem?</b>	<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) <b>is it expected to be of long-continued and indefinite duration and substantially impair ability to live independently?</b>	<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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<b>4.11: Domestic Violence</b>	
✓ <i>To be collected at project start and update.</i>	
<b>Information Date:</b>	
<b>Domestic Violence Victim/Survivor?</b>	<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) <b>when experience occurred:</b>	<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) <b>are you currently fleeing?</b>	<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

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

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

<b>BHHS Required Information</b>	
✓ <i>To be collected at entry, update and annual assessment.</i>	
<b>Homelessness and at-risk of homelessness status (as of the day before project entry):</b>	<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
<b>Zip Code of last permanent address (of 90 days or more):</b>	
<b>Zip Code quality:</b>	<input type="checkbox"/> Full or Partial <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>Is the client employed?</b>	<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) <b>what is their type of employment?</b>	<input type="checkbox"/> Full time <input type="checkbox"/> Part time
<b>Select the HUD-assigned CoC code(s) that best apply:</b>	<input type="checkbox"/> Balance of State (NH-500) <input type="checkbox"/> Manchester (NH-501) <input type="checkbox"/> Greater Nashua (NH-502)