VT HMIS Family Supportive Housing Enrollment Form

HMIS Client ID: _____ **Project Start Date: _____**

Client Profile: *Complete for ALL household members*

Household Information (List everyone living in your household, related & unrelated.)

First Name	Last Name	Relationship to HoH	SSN	Date of Birth	Race and Ethnicity
		SELF			

KEY:

- ***Relationship to Head of Household:*** *Self (HoH); Head of Household's child; Head of household's spouse or partner; Head of household's other relation member; Other: non-relation member*
- ***Race and Ethnicity:*** *American Indian, Alaska Native, or Indigenous = I; Asian or Asian American = A; Black, African American, or African = B; Hispanic/Latina/o = H/L; Middle Eastern or North African = M; Native Hawaiian or Pacific Islander = H; White= W; Additional Race and Ethnicity Detail = (please write in)*

U.S Military Veteran? *Answer for all Adults in household (18 years older)*

❑ Yes ❑ No

Gender: *Optional, non-federal field*

Woman (Girl, if child) = W; Man (Boy, if child) = M; Culturally Specific Identity=CSI; Transgender = T; Non-Binary = NB; Questioning = Q; Different Identity = (please write in)

Client Contact Information: *Complete for Head of Household*

Email Address: _____

Phone (#1) _____ Phone (#2) _____

Contact Date _____

Note: *With client permission, this would be a place to add emergency contact, alternative contact, mailing address, etc.*

_____

_____

Client Enrollment:

Housing Move-in Date *Answer for all household members; children included. Please note: Housing Move-in Date may be left blank at project enrollment if the client is not yet permanently housed.*

Housing Move-in Date: _____

Prior Living Situation: *Answer for HoH and all Adults*

Type of Residence:

-------- HOMELESS SITUATIONS -------
❑ Emergency shelter, including hotel or motel paid for with emergency shelter voucher, Host Home

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❑ Place not meant for habitation
------- INSTITUTIONAL SITUATIONS ------
❑ Foster care home or foster care group home
❑ Hospital or other residential non-psychiatric medical facility
❑ Jail, prison, or juvenile detention facility
❑ Long-term care facility or nursing home
❑ Psychiatric hospital or other psychiatric facility
❑ Substance abuse treatment facility or detox center
--- TEMPORARY HOUSING SITUATIONS ---
❑ Transitional housing for homeless persons (including homeless youth)
❑ Residential project or halfway house with no homeless criteria
❑ Hotel or motel paid for without emergency shelter voucher
❑ Host Home (non-crisis)
❑ Staying or living with family (temporary) room, apartment, or house
❑ Staying or living with friends (temporary) room, apartment, or house
--- PERMANENT HOUSING SITUATIONS ---
❑ Staying or living with family (permanent)
❑ Staying or living with friends (permanent)
❑ Rental by client, no ongoing housing subsidy
❑ Rental by client, with ongoing housing subsidy *(if selected, answer 'Rental Subsidy Type' below)*
❑ Owned by client, with ongoing housing subsidy
❑ Owned by client, no ongoing housing subsidy

Rental Subsidy Type: *Answer if 'Rental by client, with ongoing housing subsidy' is selected.*

❑ GPD TIP housing subsidy
❑ VASH housing subsidy
❑ RRH or equivalent subsidy
❑ HCV voucher (tenant or project based) (not dedicated)
❑ Public housing unit
❑ Rental by client, with other ongoing housing subsidy

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❑ Housing Stability Voucher
❑ Family Unification Program Voucher (FUP)
❑ Foster Youth to Independence Initiative (FYI)
❑ Permanent Supportive Housing
❑ Other permanent housing dedicated for formerly homeless persons

Length of Stay in Prior Living Situation:

❑ One day or less	❑ One month or more, but less than 90 days
❑ Two Day to six nights	❑ 90 days or more, but then than one year
❑ One week or more, but less than one month	❑ One year or longer

Approximate Date This Episode of Homelessness Started: _____

Number of times on the streets, in ES, or Safe Haven in the past three years:

❑ One time	❑ Two times	❑ Three times	❑ Four or more times

Total number of months homeless on the streets, in ES, or Safe Haven in the past 3 years:

❑ One month (This is first month)	❑ 4	❑ 7	❑ 10
❑ 2	❑ 5	❑ 8	❑ 11
❑ 3	❑ 6	❑ 9	❑ 12
			❑ More than 12 months

Disabling Conditions and Barriers: *Answer for all household members (Adults and Children)*

Does the client have a disabling condition? ❑Yes ❑ No

Disability Type	**Disability Determination**	**If Yes, long term?**
Alcohol Use Disability	❑Yes ❑ No	❑Yes ❑ No
Both Alcohol and Drug Use Disability	❑Yes ❑ No	❑Yes ❑ No
Drug Use Disability	❑Yes ❑ No	❑Yes ❑ No
Chronic Health Condition	❑Yes ❑ No	❑Yes ❑ No
Developmental Disability	❑Yes ❑ No	Automatically considered long term
Mental Health Disability	❑Yes ❑ No	❑Yes ❑ No
Physical	❑Yes ❑ No	❑Yes ❑ No

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HIV/AIDS	❑Yes ❑ No	Automatically considered long term

Survivor of Domestic Violence: *Answer for HoH and all Adults in household (18 years older)*

❑Yes ❑No

If Yes for domestic violence survivor, when experience occurred:

❑ Within the past three months	❑ From six to twelve months ago
❑ Three to six months ago	❑ More than a year

If Yes for domestic violence survivor, are you currently fleeing? ❑ Yes ❑ No

Monthly Income: *Answer for HoH and all Adults in household (18 years older)*

Income from Any Source: ❑Yes ❑ No Total Monthly Income: _____

Source of Income	**Receiving Income Source?**		**Monthly Amount**
Alimony or Other Spousal Support	❑Yes	❑ No	$
Child Support	❑Yes	❑ No	$
Earned Income	❑Yes	❑ No	$
General Assistance	❑Yes	❑ No	$
Other	❑Yes	❑ No	$
Pension or retirement income from another job	❑Yes	❑ No	$
Private Disability Insurance	❑Yes	❑ No	$
Retirement Income from Social Security	❑Yes	❑ No	$
SSDI	❑Yes	❑ No	$
SSI	❑Yes	❑ No	$
TANF – (VT Reach Up)	❑Yes	❑ No	$
Unemployment Insurance	❑Yes	❑ No	$
VA Non-Service Connected Disability Pension	❑Yes	❑ No	$
VA Service Connected Disability Compensation	❑Yes	❑ No	$
Workers Compensation	❑Yes	❑ No	$

Non-Cash Benefits: *Answer for HoH and all Adults in household (18 years older)*

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Non-cash benefits from any source: ❑Yes ❑ No

Source of Income	Receiving Income Source?	
Supplemental Nutrition Assistance Program (Food Stamps)	❑Yes	❑ No
Special Supplemental Nutrition Program for WIC	❑Yes	❑ No
TANF Child Services	❑Yes	❑ No
TANF Transportation Services	❑Yes	❑ No
Other TANF-Funded Services	❑Yes	❑ No
Other Source	❑Yes	❑ No

Health Insurance: *Answer for all household members (Adults and Children)*

Covered by Health Insurance: ❑Yes ❑ No

Source:		
MEDICAID	❑Yes	❑ No
MEDICARE	❑Yes	❑ No
State Children's Health Insurance Program	❑Yes	❑ No
Veteran's Health Administration (VHA)	❑Yes	❑ No
Employer – Provided Health Insurance	❑Yes	❑ No
Health Insurance obtained through Cobra	❑Yes	❑ No
Private Pay Health Insurance	❑Yes	❑ No
State Health Insurance for Adults	❑Yes	❑ No
Indian Health Services Program	❑Yes	❑ No
Other	❑Yes	❑ No

FSH Program Specific Fields:

Employment, Job Training & Education *Answer for HoH and all Adults in Household*

Employed? *(Client employed at enrollment?)*	❑Yes	❑ No
In job training and/or education program?	❑Yes	❑ No

Last Grade Completed *Answer for HoH and all Adults in Household*

❑ Less than Grade 5	❑ Some college

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❑ Grades 5 - 6	❑ Associates degree
❑ Grades 7 - 8	❑ Bachelor's degree
❑ Grades 9 – 11	❑ Graduate degree
❑ Grade 12	❑ Vocational Certification
❑ School Program does not have grade levels	❑ Client doesn't know
❑ GED	❑ Client refused

Household Composition *Answer for Head of Household Only*

Number of children 7 -17:
Number of children 6 and under:

Financial Empowerment *Answer for Head of Household Only*

Use federally insured banking services?	❑Yes	❑ No
Does client have a savings account?	❑Yes	❑ No
Does client have a checking account?	❑Yes	❑ No
Financial capability scale score at enrollment *(enter score)*		

Engagement and Social Support *Answer for Head of Household Only*

Social supports score at enrollment *(enter score)*	

Child Safety *Answer for Head of Household Only*

Is there an open DCF case at enrollment?	❑Yes	❑ No
Have you or your family ever been involved with DCF in the past?	❑Yes	❑ No

Current placement of child *Answer on Head of Household record and all Child records in household*

❑ In Home ❑ Out of Home

Child Health & Wellness *Answer for Head of Household Only*

Number of children up to date on well-child pediatric visits *(enter number)*		
Number of children receiving mental health services *(enter number)*		
Are children enrolled in a licensed or registered childcare program?	❑Yes	❑ No

Within the past 12 months we worried whether food would run out before we got money to buy more	❑ Often true	❑ Sometimes true	❑ Never true

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Within the past 12 months the food we bought just didn't last and we didn't have money to get more	❑ Often true	❑ Sometimes true	❑ Never true

Rental Support *Answer for Head of Household Only*

Affordable Housing (project-based housing, usually a tax-credit unit)	❑Yes	❑ No
CoC-funded Rapid Re-housing Subsidy	❑Yes	❑ No
Family Unification Voucher	❑Yes	❑ No
Housing Choice or "Section 8" Voucher	❑Yes	❑ No
Housing Opportunity Program ("HOP") Rapid Re-housing Subsidy	❑Yes	❑ No
Paying full rent in a market rate apartment	❑Yes	❑ No
Public Housing	❑Yes	❑ No
Transitional Housing	❑Yes	❑ No
Vermont Rental Subsidy	❑Yes	❑ No

Additional Information

Sex: *Answer for all household members (Adults and Children)*

❑ Male	❑ Female
❑ Client Doesn't Know	❑ Client Prefers Not to Answer
❑ Data Not Collected	