

VT HMIS PSHA Medicaid Program 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	Gender (retired)	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*
 - **Gender:** *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)*
 - **Race and Ethnicity:** *American Indian, Alaska Native, or Indigenous = I; Asian or Asian American = A; Black, African American, or African = B; Hispanic/Latina/e/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

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:

Please note: Housing Move-in Date may be left blank at project enrollment if the household is not yet permanently housed.

Housing Move-in Date: _____

Total Monthly Rent Amount listed on the Lease (not client subsidy): _____

Zip Code of Rental Unit: _____

Prior Living Situation: *Answer for all household members (Adults and Children)*

Type of Residence:

----- HOMELESS SITUATIONS -----
<input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher, Host Home

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

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

<input type="checkbox"/> GPD TIP housing subsidy
<input type="checkbox"/> VASH housing subsidy
<input type="checkbox"/> RRH or equivalent subsidy
<input type="checkbox"/> HCV voucher (tenant or project based) (not dedicated)
<input type="checkbox"/> Public housing unit
<input type="checkbox"/> Rental by client, with other ongoing housing subsidy

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<input type="checkbox"/> Housing Stability Voucher
<input type="checkbox"/> Family Unification Program Voucher (FUP)
<input type="checkbox"/> Foster Youth to Independence Initiative (FYI)
<input type="checkbox"/> Permanent Supportive Housing
<input type="checkbox"/> Other permanent housing dedicated for formerly homeless persons

Length of Stay in Prior Living Situation:

<input type="checkbox"/> One day or less	<input type="checkbox"/> One month or more, but less than 90 days
<input type="checkbox"/> Two Day to six nights	<input type="checkbox"/> 90 days or more, but then than one year
<input type="checkbox"/> One week or more, but less than one month	<input type="checkbox"/> 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:

<input type="checkbox"/> One time	<input type="checkbox"/> Two times	<input type="checkbox"/> Three times	<input type="checkbox"/> Four or more times
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Total number of months homeless on the streets, in ES, or Safe Haven in the past 3 years:

<input type="checkbox"/> One month (This is first month)	<input type="checkbox"/> 4	<input type="checkbox"/> 7	<input type="checkbox"/> 10
<input type="checkbox"/> 2	<input type="checkbox"/> 5	<input type="checkbox"/> 8	<input type="checkbox"/> 11
<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9	<input type="checkbox"/> 12
			<input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Both Alcohol and Drug Use Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Use Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Developmental Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	Automatically considered long term
Mental Health Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Physical	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Automatically considered long term

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

Yes No

If Yes for domestic violence survivor, when experience occurred:

<input type="checkbox"/> Within the past three months	<input type="checkbox"/> From six to twelve months ago
<input type="checkbox"/> Three to six months ago	<input type="checkbox"/> 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Child Support	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Earned Income	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
General Assistance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Pension or retirement income from another job	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Private Disability Insurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Retirement Income from Social Security	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
SSDI	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
SSI	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
TANF – (VT Reach Up)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Unemployment Insurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
VA Non-Service Connected Disability Pension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
VA Service Connected Disability Compensation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Workers Compensation	<input type="checkbox"/> Yes	<input type="checkbox"/> 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:	Receiving Income Source?	
Supplemental Nutrition Assistance Program (Food Stamps)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Special Supplemental nutrition Program for WIC	<input type="checkbox"/> Yes	<input type="checkbox"/> No
TANF Child Services	<input type="checkbox"/> Yes	<input type="checkbox"/> No
TANF Transportation Services	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other TANF-Funded Services	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other Source	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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

Covered by Health Insurance: Yes No

Source:	Receiving Income Source?	
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 Health Administration (VHA)	<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	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Additional Information

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

<input type="checkbox"/> Male	<input type="checkbox"/> Female
<input type="checkbox"/> Client Doesn’t Know	<input type="checkbox"/> Client Prefers Not to Answer
<input type="checkbox"/> Data Not Collected	

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PSHA Medicaid Program Data Elements Information:

Type of Housing/Housing Status

Ongoing tenant-based rental assistance (CoC, HCV)
Project-based subsidized housing (LIHTC, Sec8 PBV)
Affordable non-subsidized private housing
Non-subsidized housing that does not meet permanent housing standards due to habitability, short term or no lease, or unaffordability
Homeless / not yet housed

Do you have a Primary Care Physician?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Receiving Services for Mental Health Problem *This question will only populate if Mental Health Disability = Yes*

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Receiving Services for Substance Abuse Problem *This question will only populate if a Substance Use Disorder = Yes*

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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