Agency's LOGO

Head of Household Name: _____

Universal Intake Form

Head of Household

HMIS CLIENT ID#	INTAKE/ENTRY DATE
FILL-IN AFTER SERVICEPOINT ENTRY	MONTH / DAY / YEAR

NAME OF HEAD OF HOUSEHOLD (first, middle, last name, suffix (e.g., Jr, Sr, III))				Client doesn't know	Client refused
First Name		Middle Name		☐	☐
Last Name		Alias/Suffix		☐	☐
SSN			Approx. or Partial SSN Reported ☐	☐	☐
Veteran Status	☐ Yes ☐ No	*Veteran Status is on the Client Profile Tab and may need to be updated if the client is already in ServicePoint.*		☐	☐
Date of Birth			Approx. or Partial DOB Reported ☐	☐	☐
Primary Race	☐ American Indian or Alaskan Native ☐ Asian	☐ Black/African American ☐ White	☐ Native Hawaiian or Other Pacific Islander ☐ Other	☐	☐
Secondary Race (Leave Blank if None)	☐ American Indian or Alaskan Native ☐ Asian	☐ Black/African American ☐ White	☐ Native Hawaiian or Other Pacific Islander ☐ Other	NA	NA
Ethnicity	☐ Non-Hispanic/Latino	☐ Hispanic/Latino		☐	☐
Gender	☐ Male ☐ Female	☐ Transgender: M to F ☐ Transgender: F to M	☐ Doesn't identify as male, female or transgender	☐	☐
Primary Language	☐ English	☐ Spanish	☐ Other, specify:		

HOUSEHOLD INFORMATION

Relationship (to HoH)	***SELF***	Number in Household:	***Use a separate HH Member Supplemental page for each additional HH member***

DOMESTIC VIOLENCE

Domestic Violence Victim/Survivor	☐ Yes ☐ No	☐	☐
	(If Yes) how long ago was the last incident? ☐ Within the past 3 months ☐ 3-6 months ago ☐ 6-12 months ago ☐ More than a year ago ☐ Client Doesn't Know ☐ Client Refused (If Yes) are you currently fleeing? ☐ Yes ☐ No ☐ Client Does Not Know ☐ Client Refused		

Agency's LOGO

Head of Household Name: _____

LIVING SITUATION

PRIOR LIVING SITUATION: *Where was the client sleeping last night? Or, in other words, what was the client's living situation just prior to entering this project? For non-residential programs this is their current situation.*

Choose from Literally Homeless Situation OR Institutional Setting OR TH/PSH Situation. Once chosen, stay in that column.

1A. Homeless Situation

☐ Place not meant for human habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)
☐ Emergency Shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter
☐ Safe Haven

↓ ***Next Answer 2A: Length of Stay.*** ↓

1B. Institutional Situation

☐ 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

↓ ***Next Answer 2B: Length of Stay.*** ↓

1C. Temporary or Permanent Housing Situation

☐ Residential or halfway house with no homeless criteria
☐ Hotel or motel paid for without emergency shelter voucher
☐ Transitional housing for homeless persons (including homeless youth)
☐ Host home (non-crisis)
☐ Staying or living in a friend's room, apartment or house
☐ Staying or living in a family member's room, apartment or house
☐ Rental by client with GPD TIP housing subsidy
☐ Rental by client, with VASH housing subsidy
☐ Permanent housing (other than RRH) for formerly homeless persons
☐ Rental by client, with RRH or equivalent subsidy
☐ Rental by client, with Housing Choice Voucher (HCV) (tenant or project based)
☐ Rental by client in a public housing unit
☐ Rental by client, no ongoing housing subsidy
☐ Rental by client, with other ongoing housing subsidy
☐ Owned by client, with ongoing housing subsidy
☐ Owned by client, no ongoing housing subsidy

↓ ***Next Answer 2C: Length of Stay.*** ↓

2A: LENGTH OF STAY: *How long was the client in a Homeless Situation?*

☐ One Day or Less
☐ Two Days to One Week
☐ > One Week but < One Month
☐ One to Three Months
☐ > three months, but < 1 year
☐ One Year or Longer
☐ Client Does Not Know
☐ Client Refused

↓ ***Next Answer 3: Chronic Questions*** ↓

2B: LENGTH OF STAY: *How long was the client in an Institutional Situation?*

☐ One Day or Less🏳
☐ Two Days to One Week🏳
☐ > One Week but < One Month🏳
☐ One to Three Months🏳
(3 months or less)
☐ > three months, but < 1 year
☐ One Year or Longer
☐ Client Does Not Know
☐ Client Refused

🏳*If the client reported Three Months or less then answer the question below. If the client reports more than 3 months, the client is not chronic, skip the rest of this page.*

On the night before the Institutional Situation, did the client stay on the streets, in ES or SH?
☐ Yes (*proceed below to 3: Chronic Questions)*
☐ No (*the client is NOT Chronic, skip the rest of this page)*

2C: LENGTH OF STAY: *How long was the client in a Housing Situation?*

☐ One Day or Less🏳
☐ Two Days to One Week🏳
(1 week or less)
☐ > One Week but < One Month
☐ One to Three Months
☐ > three months, but < 1 year
☐ One Year or Longer
☐ Client Does Not Know
☐ Client Refused

🏳*If the client reported One Week or less then answer the question below. If the client reports 7 days or more, then the client is not chronic, skip the rest of this page.*

On the night before the TH/PH Housing Situation, did the client stay on the streets, in ES or SH?
☐ Yes (*proceed below to 3: Chronic Questions)*
☐ No (*the client is NOT Chronic, skip the rest of this page)*

Agency's LOGO

Head of Household Name: _____

3: CHRONIC QUESTIONS: *(depending on your answer in the above questions).*	
3.1: Approximate Date this current episode of homelessness began? *Have the client look back to the date of the last time the client had a place to sleep for more than 7 days that was not on the streets in ES or SH.*	M/D/Y
3.2: Regardless of where they stayed last night -- Number of times (episodes) the client has been homeless on the streets, in ES, or SH in the past three years including today. *If this is the first time the client has been homeless in the past 3 years then the response is One Time.* • *A NEW EPISODE SHOULD BE COUNTED AFTER EACH TIME THE CLIENT HAD HOUSING FOR 7 DAYS OR LONGER (AT A FRIEND'S OR FAMILY MEMBER'S OR OTHER NON-HOMELESS SITUATION) OR WAS IN AN INSTITUTIONAL SETTING FOR 90 DAYS OR MORE.*	☐ One Time ☐ Two Times ☐ Three Times ☐ Four or more times ☐ Client Doesn't Know ☐ Client Refused
3.3: Total number of months on the street, in ES or SH in the past 3 years: *the number of cumulative but not necessarily consecutive months spent homeless.*	Number of Months

Client Location

Choose the continuum where the client is located (in most cases this will be "IL-514 DuPage")

☐ IL-514 DuPage ☐ IL-502 Waukegan/North Chicago/Lake ☐ IL-512 Bloomington/Central Illinois
☐ IL-511 SubCook ☐ IL-506 Joliet/Kendall/Grundy ☐ IL-518 Northwest/LaSalle
☐ IL-517 Aurora/Elgin/Kane ☐ IL-509 De Kalb

City and Zip where client stays or spends most of their time

Current City_____ Current Zip_____

DISABILITY

Does the client have a disabling condition expected to be of long duration and impedes ability to live independently?

☐ Yes ☐ No ☐ Doesn't Know ☐ Refused

Disability Type	(If Yes) Start Date	Currently receiving Services or Treatment?	Will the Condition be long term?	Disability Determination
Alcohol Abuse ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?			☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused
	Notes:			
Drug Abuse ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?			☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused
	Notes:			
Alcohol and Drug Abuse ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?			☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused
	Notes:			
Chronic Health Condition ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?			☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused
	Notes:			

Head of Household Name: _____

HIV/AIDS ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused		
	Notes:			
Mental Health Problem ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused		
	Notes:			
Developmental Disability ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused		
	Notes:			
Physical Disability ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused		
	Notes:			

INCOME

Does the household have any current income?

☐ Yes ☐ No ☐ Client Does Not Know ☐ Client Refused

If No, move on to Household Income for AMI Below:

If Yes, indicate in each source if the household receives the income, and if they do, the household member receiving the income, the monthly amount (to the nearest dollar) of each source, and the income start date.

		HH Member	Amount	Start Date	HH Member	Amount	Start Date
Earned Income							
☐ Yes ☐ No	If Yes:		$			$	
			$			$	
Unemployment Insurance							
☐ Yes ☐ No	If Yes:		$			$	
SSI: Supplemental Security Income							
☐ Yes ☐ No	If Yes:		$			$	
Social Security Disability Income							
☐ Yes ☐ No	If Yes:		$			$	
VA Service Connected							
☐ Yes ☐ No	If Yes:		$			$	
Private Disability Insurance							
☐ Yes ☐ No	If Yes:		$			$	
Worker's Compensation							
☐ Yes ☐ No	If Yes:		$			$	

Head of Household Name: _____

Temporary Assistance for Needy Families (TANF)							
☐ Yes ☐ No	If Yes:		$			$	
General Assistance							
☐ Yes ☐ No	If Yes:		$			$	
Retirement Income from Social Security							
☐ Yes ☐ No	If Yes:		$			$	
VA Non-Service Connected							
☐ Yes ☐ No	If Yes:		$			$	
Pension from a former job							
☐ Yes ☐ No	If Yes:		$			$	
Child Support							
☐ Yes ☐ No	If Yes:		$			$	
Alimony or Other Spousal Support							
☐ Yes ☐ No	If Yes:		$			$	
Other Source (specify):							
☐ Yes ☐ No	If Yes:		$			$	

TOTAL MONTHLY HOUSEHOLD INCOME $_____ **NUMBER OF HOUSEHOLD MEMBERS** _____

FY2020 AREA MEDIAN INCOME (AMI)

Household Size	1	2	3	4	5	6	7	8
30% AMI	$1,596	$1,821	$2,050	$2,275	$2,458	$2,642	$2,825	$3,004
50% AMI	$2,654	$3,033	$3,413	$3,792	$4,096	$4,400	$4,704	$5,008
80% AMI	$4,250	$4,854	$5,463	$6,067	$6,554	$7,038	$7,525	$8,008
100% AMI	$5,308	$6,067	$6,825	$7,583	$8,192	$8,667	$9,408	$10,017

TOTAL MONTHLY HOUSEHOLD INCOME AS PERCENTAGE OF AMI:

☐ BELOW 30% ☐ 30%-49% ☐ GREATER THAN 50%

NON-CASH BENEFITS

Does the household currently receive any Non-Cash Benefits?

☐ Yes ☐ No ☐ Client Does Not Know ☐ Client Refused

Please indicate which of the following non-cash benefits have you received over the last 30 days.
(You may use "All" if all household members receive the benefit)

Food stamps or money for food on a benefits card (If yes, amount of benefit)	
☐ Yes ☐ No	If Yes, Household Members:
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	
☐ Yes ☐ No	If Yes, Household Members:
TANF child care services	
☐ Yes ☐ No	If Yes, Household Members:

Head of Household Name: _____

TANF transportation services	
☐ Yes ☐ No	If Yes, Household Members:
Other TANF-Funded Services	
☐ Yes ☐ No	If Yes, Household Members:
Other Source (specify):	
☐ Yes ☐ No	If Yes, Household Members:

HEALTH INSURANCE

Do household members currently have health insurance?

☐ Yes ☐ No ☐ Client Does Not Know ☐ Client Refused

Complete the following *(You may use "All" if all household members receive the benefit)*

Medicaid	
☐ Yes ☐ No	If Yes, Household Members:
Medicare	
☐ Yes ☐ No	If Yes, Household Members:
Illinois All Kids (State Children's Health Insurance Program)	
☐ Yes ☐ No	If Yes, Household Members:
Veteran's Administration Medical Services	
☐ Yes ☐ No	If Yes, Household Members:
Employer Provided Health Insurance	
☐ Yes ☐ No	If Yes, Household Members:
Health Insurance obtained through COBRA	
☐ Yes ☐ No	If Yes, Household Members:
Private Pay Health Insurance	
☐ Yes ☐ No	If Yes, Household Members:
State Health Insurance for Adults	
☐ Yes ☐ No	If Yes, Household Members:
Indian Health Services Program	
☐ Yes ☐ No	If Yes, Household Members:
Other	
☐ Yes ☐ No	If Yes, Household Members:
If "Yes" to Other, Specify Source:	

Agency's LOGO

Head of Household Name: _____

CLIENT'S RESIDENCE/LAST PERMANENT ADDRESS

For SSVF Projects, this is where the client lived for 90 days or more before coming to your project

Client's Street Address				Apt #	
City, Township		State		Zip	
Address Data Quality	☐ Full Address Reported ☐ Client Does Not Know		☐ Incomplete or estimated address reported ☐ Client Refused		
Phone Number		Alternate Phone			
Email Address					
Start Date		End Date			
Client's Residence Notes					
Address Type	☐ After Program ☐ Before Program-Last Permanent		☐ Before Program ☐ Program (while in your project)		

EMERGENCY CONTACT (OPTIONAL)

Contact's Name					
Client's Street Address				Apt #	
City, Township		State		ZIP	
Phone #		Second Phone #			
Relationship to Client					
Start Date		End Date			
Is there a release of information to contact this person?	☐ Yes ☐ No				

Head of Household Name: _____

[Intentionally left blank]

Agency's LOGO

Head of Household Name: _____

Universal Intake Form

Household Member

HMIS CLIENT ID#	INTAKE/ENTRY DATE
FILL-IN AFTER SERVICEPOINT ENTRY	MONTH / DAY / YEAR

NAME OF HOUSEHOLD MEMBER (first, middle, last name, suffix (e.g., Jr, Sr, III))				Client does not know	Client refused
First Name		Middle Name		☐	☐
Last Name		Alias/Suffix		☐	☐
SSN			Approx. or Partial SSN Reported ☐	☐	☐
Veteran Status	☐ Yes ☐ No	*Veteran Status is on the Client Profile Tab and may need to be updated if the client is already in ServicePoint.*		☐	☐
Relationship (to HoH)	☐ HoH's Child ☐ HoH's Spouse/Partner	☐ HoH's Other Relation ☐ Other: Non-Relation		*NA*	*NA*
Date of Birth			Approx. or Partial DOB Reported ☐	☐	☐
Primary Race	☐ American Indian or Alaskan Native ☐ Asian	☐ Black/African American ☐ White	☐ Native Hawaiian or Other Pacific Islander ☐ Other	☐	☐
Secondary Race (Leave Blank if None)	☐ American Indian or Alaskan Native ☐ Asian	☐ Black/African American ☐ White	☐ Native Hawaiian or Other Pacific Islander ☐ Other	NA	NA
Ethnicity	☐ Non-Hispanic/Latino	☐ Hispanic/Latino		☐	☐
Gender	☐ Male ☐ Female	☐ Transgender: M to F ☐ Transgender: F to M	☐ Doesn't identify as male, female or transgender	☐	☐
Primary Language	☐ English	☐ Spanish	☐ Other, specify:		
Domestic Violence Victim/Survivor	☐ Yes	☐ No		☐	☐
	(If Yes) how long ago was the last incident? ☐ Within the past 3 months ☐ 3-6 months ago ☐ 6-12 months ago ☐ More than a year ago ☐ Client Doesn't Know ☐ Client Refused (If Yes) are you currently fleeing? ☐ Yes ☐ No ☐ Client Does Not Know ☐ Client Refused				

Agency's LOGO

Head of Household Name: _____

Member Name:

DISABILITY

Does the client have a disabling condition?

☐ Yes ☐ No ☐ Doesn't Know ☐ Refused

Disability Type	(If Yes) Start Date	Currently receiving Services or Treatment?	Will the Condition be long term?	Disability Determination	Documentation of disability and severity on file
Alcohol Abuse ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused			
	Notes:				
Drug Abuse ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused			
	Notes:				
Alcohol and Drug Abuse ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused			
	Notes:				
Chronic Health Condition ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused			
	Notes:				
HIV/AIDS ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused			
	Notes:				
Mental Health Problem ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused			
	Notes:				
Developmental Disability ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused			
	Notes:				
Physical Disability ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	_____/_____/_____	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused			
	Notes:				