HMIS Data Collection Form – CoC Program - Households

Adult / Hoh

FOR USE BY COC-FUNDED PROJECTS THAT SERVE HOUSEHOLDS WITH MORE THAN ONE PERSON

HOUSEHOLD MEMBER NAME

This form is for Heads of Household and Adults only. Print additional copies as needed.

First Name	MI	Last Name	Aliases

FEDERAL REPORTING REQUIREMENTS

RELATIONSHIP TO HEAD OF HOUSEHOLD (HOH)

☐ Self (Hoh) ☐ HoH's child ☐ HoH's other relation member ☐ HoH's spouse or partner ☐ Other: non-relation member ☐ Unknown

ENROLLMENT COC

☐ AK-500 Anchorage Continuum of Care
☐ AK-501 Alaska Balance of State Continuum of Care

HOUSING MOVE-IN INFORMATION (housing projects only)

IF THE CLIENT HAS NOT MOVED INTO HOUSING AT PROJECT START, LEAVE THIS FIELD BLANK IN HMIS.

HOUSING MOVE-IN DATE

CLIENT DEMOGRAPHICS

DATE OF BIRTH

☐ Client doesn't know
☐ Client prefers not to answer

☐ Full DOB ☐ Partial DOB

RACE AND ETHNICITY

☐ Client doesn't know
☐ Client prefers not to answer

☐ American Indian, Alaska Native, or Indigenous
☐ Asian or Asian American
☐ Black, African American, or African
☐ Hispanic/Latina/e/o
☐ Middle Eastern or North African
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Additional (specify):

GENDER

☐ Client doesn't know
☐ Client prefers not to answer

☐ Woman (Girl, if child)
☐ Man (Boy, if child)
☐ Culturally Specific Identity (e.g., Two-Spirit)
☐ Transgender
☐ Non-Binary
☐ Questioning
☐ Different Identity (specify):

SEXUAL ORIENTATION (HEAD OF HOUSEHOLD AND ADULTS ONLY)

☐ Client doesn't know
☐ Client prefers not to answer

☐ Heterosexual/Straight
☐ Gay
☐ Lesbian
☐ Bisexual
☐ Questioning/Unsure
☐ Other/Additional (specify to the right) →

☐ Aromantic
☐ Asexual
☐ Demisexual
☐ Pansexual
☐ Queer
☐ Other (Ex: same gender-loving, stud)

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HEALTH INSURANCE COVERAGE INFORMATION

COVERED BY HEALTH INSURANCE?

☐ Client doesn't know
☐ Client prefers not to answer

☐ Yes (If yes, select answer for each type below.)
☐ No (If no, answer No for all types in HMIS.)

HEALTH INSURANCE TYPES (HUD TABLE)

	Yes	No		Yes	No
Medicaid	☐	☐	Health Insurance through COBRA	☐	☐
Medicare	☐	☐	Private Pay Health Insurance	☐	☐
State Children's Health Insurance Program	☐	☐	State Health Insurance for Adults	☐	☐
Veteran's Health Administration	☐	☐	Indian Health Services Program	☐	☐
Employer-Provided Health Insurance	☐	☐	Other (specify):	☐	☐

DISABLING CONDITION INFORMATION

DISABLING CONDITIONS?

☐ Client doesn't know
☐ Client prefers not to answer

☐ Yes (If yes, select answer for each type below.)
☐ No (If no, answer No for all types in HMIS.)

DISABLING CONDITIONS (HUD TABLE)

	Yes	No	Doesn't know	Prefers not to answer		Yes	No	Doesn't know	Prefers not to answer
Alcohol Use Disorder	☐	☐	☐	☐		☐	☐	☐	☐
Both Alcohol and Drug Use	☐	☐	☐	☐		☐	☐	☐	☐
Chronic Health Condition	☐	☐	☐	☐	If Yes, does it affect their ability to live independently?	☐	☐	☐	☐
Developmental	☐	☐	☐	☐					
Drug Use Disorder	☐	☐	☐	☐		☐	☐	☐	☐
HIV / AIDS	☐	☐	☐	☐					
Mental Health Disorder	☐	☐	☐	☐		☐	☐	☐	☐
Physical Disability	☐	☐	☐	☐		☐	☐	☐	☐

AK DISABLING CONDITIONS

	Yes	No	Doesn't know	Prefers not to answer
Alzheimer's Disease and Related Dementias	☐	☐	☐	☐
Chronic Alcoholism or other substance use disorder	☐	☐	☐	☐
Intellectual or Developmental Disabilities	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐
Traumatic Brain Injuries	☐	☐	☐	☐

ALASKA NATIVE REGIONAL CORPORATION

PRIMARY REGIONAL CORPORATION

☐ Client doesn't know
☐ Client prefers not to answer

☐Not Affiliated	☐Sealaska	☐Doyon Limited	☐Calista	☐Chugach Alaska
☐Bering Straits Native	☐Ahtna	☐13th Regional	☐Koniag	☐NANA Regional
☐Cook Inlet Regional	☐Bristol Bay Native	☐Aleut	☐Arctic Slope Regional	

SECONDARY REGIONAL CORPORATION, IF APPLICABLE:

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PRIOR LIVING SITUATION INFORMATION (Heads of Household and Adults only)

TYPE OF RESIDENCE: LIVING SITUATION IMMEDIATELY PRIOR TO PROJECT START

☐ Client doesn't know
☐ Client prefers not to answer

Homeless Situation
- ☐ Place not meant for habitation (for example: car, park, abandoned building, bus station, airport, tent)
- ☐ Emergency shelter (ES), including hotel or motel paid for with ES voucher, Host Home shelter

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 use treatment facility or detox center

Temporary Housing Situation
- ☐ Transitional housing for homeless persons youth (including homeless youth)
- ☐ Residential project/halfway house with no homeless criteria
- ☐ Hotel/motel paid for without ES voucher
- ☐ Host Home (non-crisis)
- ☐ Staying or living in friend's room, apartment, or house
- ☐ Staying or living in family's room, apartment, or house

Permanent Housing Situation
- ☐ Rental by client, no ongoing housing subsidy
- ☐ Rental by client, with housing subsidy (specify to the right) →
- ☐ Owned by client, with ongoing housing subsidy
- ☐ Owned by client, no ongoing housing subsidy

if Rental by client, with housing subsidy, specify only one:
- ☐ GPD TIP
- ☐ VASH
- ☐ RRH or equivalent
- ☐ Housing Choice (HCV)
- ☐ Public housing
- ☐ Other ongoing subsidy
- ☐ Family Unification Program (FUP)
- ☐ Foster Youth to Independence (FYI)
- ☐ Permanent Supportive Housing (PSH)
- ☐ Other PH dedicated to formerly homeless

LENGTH OF STAY IN LIVING SITUATION IMMEDIATELY PRIOR TO PROJECT START

☐ Client doesn't know
☐ Client prefers not to answer

- ☐ One night or less
- ☐ Two to six nights
- ☐ One week or more, but less than a month
- ☐ One month or more, but less than 90 days
- ☐ 90 days or more, but less than one year
- ☐ One year or longer

IF THE CLIENT IS CURRENTLY EXPERIENCING HOMELESSNESS, ANSWER THE FOLLOWING.

APPROXIMATE DATE THIS CURRENT EPISODE OF HOMELESSNESS STARTED

_____/_____/_____

IF THE CLIENT HAS EXPERIENCED HOMELESSNESS IN THE PAST THREE YEARS, ANSWER THE FOLLOWING.

NUMBER OF EPISODES OF HOMELESSNESS IN THE PAST THREE YEARS INCLUDING TODAY

☐ Client doesn't know
☐ Client prefers not to answer

- ☐ 1 time
- ☐ 2 times
- ☐ 3 times
- ☐ 4 or more times

IF THE CLIENT HAS EXPERIENCED HOMELESSNESS IN THE PAST THREE YEARS, ANSWER THE FOLLOWING.

NUMBER OF MONTHS HOMELESS IN THE PAST THREE YEARS INCLUDING THIS MONTH

☐ Client doesn't know
☐ Client prefers not to answer

- ☐ 1 month (1st month in the past 3 years)
- ☐ 2 months
- ☐ 3 months
- ☐ 4 months
- ☐ 5 months
- ☐ 6 months
- ☐ 7 months
- ☐ 8 months
- ☐ 9 months
- ☐ 10 months
- ☐ 11 months
- ☐ 12 months
- ☐ More than 12 months

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DV INFORMATION

DOMESTIC VIOLENCE VICTIM/SURVIVOR?

☐ Client doesn't know
☐ Client prefers not to answer

☐ Yes (If yes, select answer for each question below.)
☐ No

When did the last experience occur?
☐ Within past 3 months ☐ 6 to 12 months ago
☐ 3 to 6 months ago ☐ More than a year ago

☐ Client doesn't know
☐ Client prefers not to answer

Are you currently fleeing?
☐ Yes
☐ No

☐ Client doesn't know
☐ Client prefers not to answer

MONTHLY INCOME INFORMATION

INCOME FROM ANY SOURCE?

☐ Client doesn't know
☐ Client prefers not to answer

☐ Yes (If yes, select answer for each type below.)
☐ No (If no, answer No for all types in HMIS.)

SOURCES OF INCOME (HUD TABLE)

	Yes (specify)	No		Yes (specify)	No
Alimony/Other spousal support	☐ $	☐	Retirement income from social security	☐ $	☐
Child support	☐ $	☐	SSDI	☐ $	☐
Earned income	☐ $	☐	SSI	☐ $	☐
General assistance	☐ $	☐	TANF	☐ $	☐
Other: AK Permanent Fund Dividend (PFD)	☐ $	☐	Unemployment insurance	☐ $	☐
Other: AK Native Corp. Dividend	☐ $	☐	VA non-svc connected disability pension	☐ $	☐
Other (specify):	☐ $	☐	VA svc connected disability compensation	☐ $	☐
Pension/Retirement income	☐ $	☐	Worker's Compensation	☐ $	☐
Private disability insurance	☐ $	☐	**Total Monthly Income: $**		

NON-CASH BENEFITS INFORMATION

NON-CASH BENEFITS FROM ANY SOURCE?

☐ Client doesn't know
☐ Client prefers not to answer

☐ Yes (If yes, select answer for each type below.)
☐ No (If no, answer No for all types in HMIS.)

SOURCES OF NON-CASH BENEFITS (HUD TABLE)

	Yes	No		Yes	No
TANF Child Care Services	☐	☐	SNAP (Food Stamps)	☐	☐
Special Supp. Nutrition Program for WIC	☐	☐	Other TANF-Funded Services	☐	☐
TANF Transportation Services	☐	☐	Other (specify):	☐	☐

TRANSLATION ASSISTANCE INFORMATION

TRANSLATION ASSISTANCE NEEDED?

☐ Client doesn't know
☐ Client prefers not to answer

☐ Yes (If yes, specify preferred language below.)
☐ No

Preferred Language

☐ English
☐ Spanish
☐ Akuzipigestun / St. Lawrence Island Yupik (aka Siberian Yupik)
☐ Alutiiq
☐ Atnakenaege' / Ahtna
☐ Central Alaskan Yup'ik / Yugtun
☐ Gwich'in
☐ Hawaiian
☐ Inupiatun / Inupiaq
☐ Koyukon
☐ Russian
☐ Samoan
☐ Tagalog
☐ Tanacross
☐ Tanana
☐ Tlingit
☐ Unangam Tunuu / Aleutian Aleut
☐ Upper Kuskokwim
☐ Xaat Kíl / Haida
☐ Yupik
☐ Different Preferred Language (Specify below.)
☐ Client doesn't know
☐ Client prefers not to answer

If Different Preferred Language, please specify: