

HMIS Data Collection Form – BHAP and SNHG - Households

FOR USE BY BHAP AND SNHG PROGRAMS THAT SERVE HOUSEHOLDS WITH MORE THAN ONE PERSON

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

First Name	MI	Last Name	Aliases

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

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

GENDER

- Client doesn’t know
 Client prefers not to answer

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

SEXUAL ORIENTATION (HEAD OF HOUSEHOLD AND ADULTS ONLY)

- Client doesn’t know
 Client prefers not to answer

- Heterosexual/Straight
 Lesbian
 Questioning/Unsure
 Gay
 Bisexual
 Other/Additional (specify to the right) →
- Aromantic
 Pansexual
 Asexual
 Queer
 Demisexual
 Other (Ex: same gender-loving, stud)

DISABLING CONDITIONS?

- Client doesn’t know
 Client prefers not to answer

- Yes
 No

AK DISABLING CONDITIONS

	Yes	No	Doesn’t know	Prefers not to answer
Alzheimer’s Disease and Related Dementias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Alcoholism or other substance use disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual or Developmental Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traumatic Brain Injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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PRIMARY REGIONAL CORPORATION					<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Not Affiliated	<input type="checkbox"/> Sealaska	<input type="checkbox"/> Doyon Limited	<input type="checkbox"/> Calista	<input type="checkbox"/> Chugach Alaska	
<input type="checkbox"/> Bering Straits Native	<input type="checkbox"/> Ahtna	<input type="checkbox"/> 13 th Regional	<input type="checkbox"/> Koniag	<input type="checkbox"/> NANA Regional	
<input type="checkbox"/> Cook Inlet Regional	<input type="checkbox"/> Bristol Bay Native	<input type="checkbox"/> Aleut	<input type="checkbox"/> Arctic Slope Regional		
SECONDARY REGIONAL CORPORATION, IF APPLICABLE:					

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

TYPE OF RESIDENCE: LIVING SITUATION IMMEDIATELY PRIOR TO PROJECT START		<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
Homeless Situation	<input type="checkbox"/> Place not meant for habitation (for example: car, park, abandoned building, bus station, airport, tent) <input type="checkbox"/> Emergency shelter (ES), including hotel or motel paid for with ES voucher, Host Home shelter	
Institutional Situation	<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 use treatment facility or detox center	
Temporary Housing Situation	<input type="checkbox"/> Transitional housing for homeless persons youth (including homeless youth) <input type="checkbox"/> Residential project/halfway house with no homeless criteria <input type="checkbox"/> Hotel/motel paid for without ES voucher <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Staying or living in friend's room, apartment, or house <input type="checkbox"/> Staying or living in family's room, apartment, or house	
Permanent Housing Situation	<input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with housing subsidy (specify to the right) → <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy	if Rental by client, with housing subsidy, specify only one: <input type="checkbox"/> GPD TIP <input type="checkbox"/> VASH <input type="checkbox"/> RRH or equivalent <input type="checkbox"/> Housing Choice (HCV) <input type="checkbox"/> Public housing <input type="checkbox"/> Other ongoing subsidy <input type="checkbox"/> Family Unification Program (FUP) <input type="checkbox"/> Foster Youth to Independence (FYI) <input type="checkbox"/> Permanent Supportive Housing (PSH) <input type="checkbox"/> Other PH dedicated to formerly homeless

LENGTH OF STAY IN LIVING SITUATION IMMEDIATELY PRIOR TO PROJECT START		<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> One night or less	<input type="checkbox"/> One week or more, but less than a month	<input type="checkbox"/> 90 days or more, but less than one year
<input type="checkbox"/> Two to six nights	<input type="checkbox"/> One month or more, but less than 90 days	<input type="checkbox"/> 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		<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> 1 time		
<input type="checkbox"/> 2 times		
<input type="checkbox"/> 3 times		
<input type="checkbox"/> 4 or more times		

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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			<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> 1 month (1 st month in the past 3 years)	<input type="checkbox"/> 6 months	<input type="checkbox"/> 10 months	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> 2 months	<input type="checkbox"/> 7 months	<input type="checkbox"/> 11 months	
<input type="checkbox"/> 3 months	<input type="checkbox"/> 8 months	<input type="checkbox"/> 12 months	
<input type="checkbox"/> 4 months	<input type="checkbox"/> 9 months	<input type="checkbox"/> More than 12 months	
<input type="checkbox"/> 5 months			

DOMESTIC VIOLENCE VICTIM/SURVIVOR?		<input type="checkbox"/> Client doesn't know	
<input type="checkbox"/> Yes (If yes, select answer for each question below.)		<input type="checkbox"/> Client prefers not to answer	
<input type="checkbox"/> No			
<i>When did the last experience occur?</i>	<input type="checkbox"/> Within past 3 months	<input type="checkbox"/> 6 to 12 months ago	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> 3 to 6 months ago	<input type="checkbox"/> More than a year ago	<input type="checkbox"/> Client prefers not to answer
<i>Are you currently fleeing?</i>	<input type="checkbox"/> Yes		<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> No		<input type="checkbox"/> Client prefers not to answer