

DUPAGE COUNTY HMIS STANDARD OPERATING PROCEDURES

Approved 1/8/2020

The mission of the HMIS Team is to provide visionary data leadership by providing an effective and usable case management tool and by collecting and analyzing client and program-level data to report on the extent and nature of homelessness

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Section 1- Introduction & Responsibilities

Introduction

The Homeless Management Information System (HMIS) is a database platform designed to capture uniform client information over time. This system is essential to efforts to streamline client services and inform public policy. Through HMIS, clients benefit from improved coordination in and between Participating Agencies within their respective Continuum of Care (CoC), informed advocacy efforts, and policies that result in targeted services. Analysis of information gathered by HMIS is critical to accurately calculate the size, characteristics, and needs of homeless and at-risk populations; data necessary to serve clients appropriately and for systems planning and advocacy.

Agencies who receive funding through the following federal partners and their respective programs are to participate in their local HMIS: U.S. Department of Health and Human Services, U.S. Department of Housing and Urban Development, U.S. Department of Veteran Affairs.

The DuPage County Continuum of Care participates in the Northeast Illinois HMIS (NIL HMIS). The NIL HMIS is a shared, regional HMIS which multiple CoC's participate in and is managed by a single Technical Lead Agency, the Alliance to End Homelessness in Suburban Cook County.

This document provides the policies and procedures that govern the DuPage County Continuum of Care Homeless Management Information System and those who use it. They are collectively referred to as the Standard Operating Procedures (SOP). The SOP have been developed in order to comply with HUD regulations, state and federal laws and to retain consistency in developing and maintaining the HMIS. The DuPage County CoC HMIS Policy Committee is responsible for reviewing the SOP annually and proposing changes for approval by the DuPage County CoC Leadership Committee.

Roles and Responsibilities

The following documents outline the various roles and responsibilities as it relates to the DuPage County Continuum of Care Homeless Management Information System, in addition to the policies and procedures as outlined in the Standard Operating Procedures. These documents can be located on the HMIS website, dupageco.org/HMIS.

[Memorandum of Understanding between and amongst the Cook County Continuum of Care, the DuPage County Continuum of Care, DuPage County and the Alliance to End Homelessness in Suburban Cook County](#)

This document outlines the regional governing structure of the HMIS including the regional governing forum, the HMIS technical lead agencies, local CoCs and local HMIS Leads.

[Memorandum of Understanding between the DuPage County Continuum of Care and DuPage County Department of Community Services](#)

This document designates the DuPage County Department of Community Services as the HMIS Lead and describes its responsibilities as the HMIS Lead.

[HMIS Partner Agreement between DuPage County Community Services and the Participating Agency](#)

This document describes the responsibilities of HMIS participating agencies and their users.

[HMIS Agency Data Administrator Policy and Code of Ethics](#)

The Executive Director of each participating agency must designate a user at the agency to act as the lead user for this agency. This agreement outlines the roles and responsibilities of the Agency Data Administrator.

[HMIS End User Policy and Code of Ethics](#)

This agreement describes the responsibilities and code of ethics that a HMIS user must abide by.

[NIL HMIS System Administrator Plan](#)

Outlines the NIL HMIS roles and requirements as it applies to local policies and procedures and management of the HMIS.

Section 2: Privacy Plan

Privacy Plan Overview

On July 30, 2004, the US Department of Housing and Urban Development (HUD) released the standards for Homeless Management Information Systems (69 Federal Register 45888). This standard outlines the responsibilities of the HMIS and for the agencies which participate in a HMIS. This section of our Standard Operating Procedure describes the Privacy Plan of the DuPage County HMIS System. We intend our policy and plan to be consistent with the HUD standards. All users, agencies and system administrators must adhere to this Privacy Plan.

We intend our Privacy Plan to support our mission of providing an effective and usable case management tool. We recognize that clients served by individual agencies are not exclusively that “agency’s client” but instead are truly a client of the DuPage County Continuum of Care. Thus, we have adopted a Privacy Plan which supports an open system of client-level data sharing amongst agencies.

The core tenant of our Privacy Plan is the Baseline Privacy Notice. The Baseline Privacy Notice describes how client information may be used and disclosed and how clients can get access to their information. Each agency must either adopt the Baseline Privacy Notice or develop a Privacy Notice which meets and exceeds all minimum requirements set forth in the Baseline Privacy Notice (this is described in the Agency Responsibilities section of this Privacy Plan). This ensures that all agencies who participate in the HMIS are governed by the same minimum standards of client privacy protection. Although the Baseline Privacy Notice and its related forms are appendices to this section, they act as the cornerstone of our Privacy Plan.

All amendments to the Privacy Plan (including changes to the Baseline Privacy Notice and related forms) are proposed by the HMIS Committee and approved by the Leadership Committee of the DuPage County Continuum of Care.

Privacy Plan Documents & Forms	Description	Use by Agency
Baseline Privacy Notice	This is the main document of this Privacy Plan. This document outlines the minimum standard by which an agency collects, utilizes and discloses information.	*REQUIRED* Agencies must adopt a privacy notice which meets all minimum standards.
Privacy Posting	This posting explains the reason for asking for personal information and notifies the client of the Privacy Notice.	*REQUIRED* Agencies must adopt and utilize a Privacy Posting.
Client Data Sharing Refusal Form	This form gives the client the opportunity to refuse the sharing of their information to	*REQUIRED* -if adopting baseline privacy notice* If the agency adopts the baseline privacy

	other agencies within the system.	notice, they must have this form available for the client.
Acknowledgement of Receipt	This form provides physical documentation that the client was informed of the privacy notice and their rights regarding opting-out of data sharing.	*Optional* Agencies are encouraged, but not required to utilize this form.

User Responsibilities

A client’s privacy is upheld only to the extent that the users and direct service providers protect and maintain their privacy. The role and responsibilities of the user cannot be over-emphasized. A user is defined as a person that has direct interaction with a client or their data. (This could potentially be any person at the agency: a staff member, volunteer, contractor, etc.)

Users have the responsibility to:

- Understand their agency’s Privacy Notice
- Be able to explain their agency’s Privacy Notice to clients
- Follow their agency’s Privacy Notice
- Know where to refer the client if they cannot answer the client’s questions
- Present their agency’s Privacy Notice to the client before collecting any information
- Uphold the client’s privacy in the HMIS

Agency Responsibilities

The 2004 HUD HMIS Standards emphasize that it is the agency’s responsibility for upholding client privacy. All agencies must take this task seriously and take time to understand the legal, ethical and regulatory responsibilities. This Privacy Plan and the Baseline Privacy Notice provide guidance on the minimum standards by which agencies must operate if they wish to participate in the HMIS.

Meeting the minimum standards in this Privacy Plan and the Baseline Privacy Notice are required for participation in the HMIS. Any agency may exceed the minimum standards described and are encouraged to do so. Agencies must have an adopted Privacy Notice which meets the minimum standards before data entry into the HMIS can occur.

Agencies have the responsibility to:

- Review their program requirements to determine what industry privacy standards must be met that exceed the minimum standards outlined in this Privacy Plan and Baseline Privacy Notice (examples: Substance Abuse Providers covered by 24 CFR Part 2, HIPPA Covered Agencies, Legal Service Providers).
- Review the 2004 HUD HMIS Privacy Standards (69 Federal Register 45888)
- Adopt and uphold a Privacy Notice which meets or exceeds all minimum standards in the Baseline Privacy Notice as well as all industry privacy standards. The adoption process is to be directed by the individual agency. Modifications to the Baseline Privacy Notice must be approved

by the HMIS Committee.

- Ensure that all clients are aware of the adopted Privacy Notice and have access to it. If the agency has a website, the agency must publish the Privacy Notice on their website.
- Make reasonable accommodations for persons with disabilities, language barriers or education barriers.
- Ensure that anyone working with clients covered by the Privacy Notice can meet the User Responsibilities.
- Designate at least one user that has been trained to technologically uphold the agency's adopted Privacy Notice.

System Administration Responsibilities

DuPage County Community Services HMIS Staff have the responsibility to:

- Adopt and uphold a Privacy Notice which meets or exceeds all minimum standards in the Baseline Privacy Notice.
- Train and monitor all users with System Administrator access on upholding system privacy.
- Monitor agencies to ensure adherence to their adopted Privacy Notice.
- Develop action and compliance plans for agencies that do not have adequate Privacy Notices.
- Maintain the HMIS Website to keep all references within the Baseline Privacy Notice up to date.
- Provide training to agencies and users on this Privacy Plan.

Section 3- Data Quality Plan

Introduction to Data Quality

Data quality refers to the extent that data recorded in HMIS accurately reflects the same information in the real world. To meet the HMIS goal of reporting on the extent and nature of homelessness, it is critical that HMIS has the best possible representation of reality as it relates to homeless people and the programs that serve them. Specifically, it should be our goal to record the most accurate, consistent and timely information to draw reasonable conclusions about the extent of homelessness and the impact of homeless services. To best ensure we are achieving good data quality, all data entry must be captured using a HMIS Staff approved workflow.

Data elements included in this Data Quality Plan are determined by the US Department of Housing and Urban Development (HUD), all Federal Partners, and the DuPage Continuum of Care. This plan is written to comply with the most recent version of the HMIS Data Standards Manual and Data Dictionary¹. The HMIS Data Standards Manual and Data Dictionary describe what information must be collected, for which projects, persons and at which point in time. This section is not intended to replace the details of that document but to establish local thresholds for data quality errors based on program and funding type.

The Data Quality Plan applies to all participating HMIS projects regardless of project type or funding source, but some data elements may only be required for specific project types as noted in the table below. Not all data elements will be included in this plan, and projects should be mindful to routinely review their program manuals² for further guidance.

Data Coverage

The concept of data coverage refers to the sample size and diversity of the agencies and programs who utilize the HMIS. If we want an accurate picture of our community, we must not overlook any agency or program providing services within the Continuum of Care. It is important to note that this includes HUD funded and non-HUD funded programs and agencies.

Bed Coverage Rate

DuPage Continuum of Care has set a threshold of 100% bed coverage rates for dedicated homeless lodging providers in HMIS, excluding any domestic violence provider. Domestic Violence providers' bed coverage data will be submitted to HMIS annually or more frequently as needed. The Bed Coverage Rate

¹ <https://www.hudexchange.info/resource/3824/hmis-data-dictionary/>

² <https://www.hudexchange.info/programs/hmis/hmis-guides/#project-setup-and-data-collection-resources>

is calculated by project type,

$$= \frac{\text{\# dedicated homeless beds in DuPage CoC HMIS}}{\text{\# dedicated homeless beds in the DuPage CoC}}$$

Other

The HMIS Committee, along with the partnership of the Continuum of Care’s Leadership and Needs Assessment Committees, will continue to evaluate the data needs of the community and will address those needs as appropriate, including but not limited to the inclusion of new HMIS participating agencies, the inclusion of new data elements, and the furthering of current data analysis.

Data Quality

Data Quality is broken down into 5 equally important components: Completeness, Timeliness, Accuracy, Training and Consistency. Each of these components must be individually monitored by those completing the data entry, Agency Data Administrators, and System Administrators.

Completeness

- HMIS Staff are to ensure that the Project Descriptor Data Elements are complete for all homeless system³ and prevention⁴ projects and that the data is reviewed annually for each project with each Agency Data Administrator.
- Each HMIS participating agency, project, Agency Data Administrator and user entering data into HMIS must ensure that Client Records have complete data elements that accurately reflect the client situation at that point in time, achieving an Error Rate⁵ less than the amount as specified in the Data Quality Error Rate Thresholds Table

Data Quality Error Rate Thresholds

Element Type	Data Element	Project Type	Client	Collection Point	Error Rate Threshold	Tools to Measure
Universal Data Element	Name and Name Data Quality	All	All	Record Creation	5%	– Data Quality Framework – APR

³ Homeless System Project must meet the following:

- a. The primary intent of the project is to serve homeless persons
- b. The project verifies homeless status as part of its eligibility determination
- c. The actual project clients are predominantly homeless (or, for permanent housing, were homeless at entry).

Homelessness is to be defined by the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH), where at this time Category 3 is not approved by HUD.

⁴ Homelessness Prevention Project is a project that offers services and/or financial assistance necessary to prevent a person from moving into an emergency shelter or place not meant for human habitation.

⁵ Error Rate includes null, don’t know/refused, and incongruent data

						– ESG CAPER
Universal Data Element	Social Security Number (SSN) and SSN Data Quality	All	All	Record Creation	10%	– Data Quality Framework – APR – ESG CAPER
Universal Data Element	Date of Birth and Date of Birth Data Quality	All	All	Record Creation	5%	– Data Quality Framework – APR – ESG CAPER
Universal Data Element	Race	All	All	Record Creation	5%	– Data Quality Framework – APR – ESG CAPER
Universal Data Element	Ethnicity	All	All	Record Creation	5%	– Data Quality Framework – APR – ESG CAPER
Universal Data Element	Gender	All	All	Record Creation	5%	– Data Quality Framework – APR – ESG CAPER
Universal Data Element	Veteran Status	All	All	Record Creation	10%	– Data Quality Framework – APR – ESG CAPER
Universal Project Stay Element	Disabling Condition (Y/N)	All	All	Project Start	10%	– Data Quality Framework – APR – ESG CAPER
Universal Project Stay Element	Project Start Date	All	All	Project Start	10%	– Data Quality Framework – APR – ESG CAPER
Universal Project Stay Element	Destination at Exit	NBN ES and SO	All	Project Exit	40%	– Data Quality Framework – APR – ESG CAPER
Universal Project Stay Element	Destination at Exit	All but NBN ES and SO	All	Project Exit	10%	– Data Quality Framework – APR – ESG CAPER
Universal Project Stay Element	Relationship to Head of Household	All	All	Project Start	10%	– Data Quality Framework – APR – ESG CAPER
Universal Project Stay Element	Client Location	All	Head of Household	Project Start, Update	10%	– Data Quality Framework – APR – ESG CAPER

Universal Project Stay Element	Prior Living Situation	All	Head of Household, Adults	Project Start	10%	– APR – ESG CAPER
Universal Project Stay Element	Prior Living Situation: Chronic Homeless Status	All	Head of Household, Adults	Project Start	10%	– Data Quality Framework – APR – ESG CAPER
Program Specific Data Element	Income	All, but NBN ES	Head of Household, Adults	Project Start, Update, Annual, Exit	10%	– Data Quality Framework – APR – ESG CAPER
Program Specific	Non-Cash Benefits	All, but NBN ES	Head of Household, Adults	Project Start, Update, Annual, Exit	10%	– Data Quality Framework – APR – ESG CAPER
Program Specific	Health Insurance	All, but NBN ES	All	Project Start, Update, Annual, Exit	10%	– APR – ESG CAPER
Program Specific	Disability	All	All	Project Start, Update, Exit	10%	– APR – ESG CAPER
Program Specific	Domestic Violence	All	Head of Household, Adults	Project Start, Update	10%	– APR – ESG CAPER
Program Specific	Current Living Situation and Engagement	NBN ES and SO	Head of Household, Adults	Occurrence Point	10%	– ESG CAPER
Program Specific	Bed Nights	NBN ES	All	Occurrence Point	10%	– ES-DQ-Services to Exit Trifecta – ESG CAPER
Program Specific	Percent of AMI	All	Head of Household, Adults	Project Start, Update, Annual, Exit	10%	– Basic Demographic and EE Details – SSVF Export (for SSVF projects only)

Timeliness

To ensure accuracy of our data at any given time, HMIS data entry is to be completed in less than 7 days of the client interaction. Timeliness standards apply to all projects and information collected and entered into HMIS, including but not limited to assessment data, project entries, annual reviews, project exits,

and service transactions.

Our committee has determined timeliness thresholds for Entry and Annual reviews, as shown in the Timeliness Thresholds table below, with the goal of continued improvement over time. No project can retroactively improve this measure but can establish protocols to help ensure timely data entry going forward. Given our HMIS’s capabilities, we have determined that we are unable to provide an accurate measure of timeliness at Exit. We will continue to work with our Vendor to address this matter and will utilize quarterly point-in-time reporting and project specific reports to help ensure timely project exits.

Timeliness Thresholds

Timeliness Measure	Description	Project Type	Threshold: 7+ Days	Tools to Measure
Program Start	A Program Start Date will be created in less than 7 days of the first day of service (ES, TH, SSO), contact (SO), or eligibility determination (all PH). The Program Start Date will be equal to the first day of service (ES, TH, SSO), contact (SO), or eligibility determination (PH).	All	25%	<ul style="list-style-type: none"> – Data Quality Framework – APR – ESG CAPER
Annual Review	Required for all clients in a project for 365 days or more. Annual Reviews must be completed within 30 days from the anniversary of the Head of Household’s project start date.	All	25%	<ul style="list-style-type: none"> – Data Quality Framework – APR – ESG CAPER
Program Exit	A Program Exit Date will be recorded in HMIS in less than 7 days of learning of the client’s last service date or residence date. The Exit Date will be equal to the last day of service or residence.	All, but NBN ES and SO	Not Available	<p>NONE – Our system does not capture the date an Exit record is created, but rather when the Entry/Exit record is updated. This is not an accurate reflection of when an Exit is created, therefore we are unable to accurately measure the timeliness of this data element.</p> <p>We recommend agencies utilize current reporting to spot check for accurate service and bed utilization. Those reports include:</p> <ul style="list-style-type: none"> – Data Quality Framework – APR – ESG CAPER
Program Exit	A Program Exit Date will be recorded in HMIS in less than 7 days of learning of the client leaving the program, or when it has been 30 days since the last Shelter Stay (NBN) or Contact (SO). The Exit Date will be equal to the last day of shelter (NBN) or Contact (SO).	NBN ES, SO	Not Available	<p>NONE – Our system does not capture the date an Exit record is created, but rather when the Entry/Exit record is updated. This is not an accurate reflection of when an Exit is created, therefore we are unable to</p>

				<p>accurately measure the timeliness of this data element.</p> <p>We recommend agencies utilize current reporting to spot check for accurate service and bed utilization. Those reports include:</p> <ul style="list-style-type: none"> - ESG CAPER - Trifecta
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Accuracy

We cannot assume that all information given to us by clients is truthful or that all data is always entered correctly. Inaccurate data may be intentional or unintentional. In general, false or inaccurate information is worse than incomplete information, since with the latter, it is at least possible to acknowledge the gap. Thus, it should be emphasized to clients and staff that it is better to enter nothing (or preferably “Data not collected”) than to enter inaccurate information. Agencies are required to monitor their own accuracy using some of the following guidelines:

- If using paper assessments, ensure that all required data elements are included, matching all client options and wording. DuPage has made a Universal Intake form available online, www.dupageco.org/HMIS.
- Review data quality and program specific reports for inaccurate information (pregnant males, minor veterans, etc.)
- Ensure the client understands what is being asked of them, what their options are, and that staff do not stray from the intent of the question.
- Audit a random sample of client records
- Review answers to questions with clients at subsequent interactions, at minimum on an annual basis.
- Ensure accurate project start, annual review, and exit dates for all participants. (See Timeliness Threshold Table).

Annually, System Administrators will audit a random selection of client files during the HMIS site visit to assess for tools that align with the required data elements and whether this data is accurately captured at all required points in time (program Start, Annual and Exit). A list of client Id’s will be provided in advance of the visit to each agency.

Training

End User training is a major component to a data quality plan. The roles and responsibilities of training users is outlined in the following: Section 1 of this SOP, DuPage Continuum of Care and HMIS Memorandum of Understanding, HMIS Partnership Agreement, Agency Data Administrator Agreement,

and the End User Agreement.

All users must complete a new user training prior to receiving access to the HMIS. Training may be provided through the System or Agency Data Administrator. New user training must review the Standard Operating Procedures and the Standard Workflow, in addition to any project specific information.

New users may take a self-guided online End User certification exam that covers topics from the new user training. Users must obtain a 75% or better to pass the test. While this exam is not a requirement for accessing the system, agencies are encouraged to have at least 50% of their users pass the certification test.

To stay current and maintain access to HMIS, all Users must complete an annual re-training provided by System Administrators. Training topics will vary each year depending on the needs of the system.

Agency Data Administrators or an agency/program representative must attend all scheduled Agency Data Administrator trainings, and in turn relay this information to the agency users.

If, at any time, a user is not able to demonstrate proper use or knowledge of the system or has not completed the required training, they will lose access to the system.

Consistency

The ability to generate system-level reports is dependent upon a common definition of fields, question wording and data entry/workflow. It is up to each agency to ensure adherence to HMIS Staff approved workflows.

Monitoring Data Quality

Monitoring Data Quality is a shared responsibility between the participating agency, HMIS Staff and the HMIS Policy Committee. Each of the 5 elements of data quality (Completeness, Timeliness, Accuracy, Training and Consistency) is to be monitored.

Agency/Program data quality is to be monitored by the Agency Data Administrator on a monthly basis. Each agency may choose different reports to monitor their data quality.

Each Agency Data Administrator should work with the HMIS Staff to ensure they are running correct data quality reports. HMIS Staff may set up a schedule by which agencies are required to submit specific data quality reports to the HMIS Lead for review.

As a guideline, the HUD CoC APR is the recommended report for monitoring agency data quality. It touches on all areas of data quality and allows Agency Data Administrators an opportunity to simultaneously monitor project performance. The following reports should additionally be considered for monitoring data quality:

Agency Reports	Annual Performance Report (APR)/ESG CAPER	Data Quality Framework	Point-In-Time and Housing Inventory Reports	Project specific reports	Frequency
Data Completeness	x	x	x	x	Monthly or more frequently
Incongruities	x	x	x	x	Monthly or more frequently
Timeliness of Data Entry	x	x	x	x	Monthly or more frequently
Project Performance	x		x	x	Quarterly or more frequently

System data quality & performance is to be monitored by the HMIS Lead on a monthly basis. This may be done by requesting agencies to submit specified data quality reports and/or monitoring data quality directly in the system. The HMIS Lead should report any concerns to the HMIS Policy Committee.

System Reports	Annual Performance Report (APR)	Data Quality Framework	Duplicate Client	User Last Login	System Growth Reports	Point-In-Time and Housing Inventory Reports	System Performance Measures	Longitudinal System Analysis (LSA)	Other reports as needed	Frequency
Data Quality	x	x	x			x	x	x	-	Quarterly or more frequently
System Utilization				x					-	Monthly or more frequently
System Performance		x			x	x	x	x	-	Semi-Annually or more frequently

Section 4- Security Plan

Introduction to the HMIS Security Plan

HMIS security standards are established to ensure the confidentiality, integrity and availability of all HMIS information. The security standards are designed to protect against any reasonably anticipated threats or hazards to security and must be enforced by system administrators, agency administrators as well as end users. This section is written to comply with section 4.3 of the 2004 Homeless Management Information Systems (HMIS) Data and Technical Standards Final Notice (69 Federal Register 45888) as well as local legislation pertaining to maintaining an individual's personal information. In December 2013, HUD released proposed regulations pertaining to HMIS Security. These regulations are not yet in force and sufficient guidance has not been given to enact the policies.

Meeting the minimum standards in this Security Plan is required for participation in the HMIS. Any agency may exceed the minimum standards described in this plan and are encouraged to do so. All Agency Data Administrators are responsible for understanding this policy and effectively communicating the Security Plan to individuals responsible for security at their agency.

Security Plan Applicability

The HMIS System and all agencies must apply the security standards addressed in this Security Plan to all the systems where personal protected information is stored or accessed. Additionally, all security standards must be applied to all networked devices. This includes, but is not limited to, an agency's networks, desktops, laptops, mobile devices, mainframes and servers.

All agencies, including the HMIS Lead, will be monitored by the HMIS System Administrators annually to ensure compliance with the Security Plan. Agencies that do not adhere to the security plan will be given a reasonable amount of time to address any concerns. Egregious violations of the security plan may result in immediate termination of an agency or user's access to the HMIS as determined by the HMIS Lead.

System Security

User Authentication

Agency Data Administrators and System Administrators shall limit access to those who meet each of the following –

- Access is required for the purpose of data assessment, entry, or reporting
- New User Training has been completed including the Standard Operating Procedures, Agency Privacy Policies, the Standard Workflow, and the overall HMIS software orientation.
- User is covered by the agency privacy notice
- User has signed and agreed to the HMIS End User Policy and Code of Ethics.
- Have an agency email address to ensure HMIS access is granted to active employees only. Publicly available domain names are not appropriate (gmail.com, Hotmail.com, etc.) unless the

agency uses these domain names as their agency standard.

It is the responsibility of Agency Data Administrators to immediately inactivate a user and notify System Administrators when the person leaves the agency or no longer requires access to the HMIS. Users who have not successfully logged into HMIS for 30 or more days may be inactivated by the System Administrator to further assure that access is only granted to those who require it.

The HMIS System only permits users to be logged into HMIS from one workstation or device at any given time.

User access and user access levels will be determined by the System Administrator in consultation with the Agency Data Administrator. The roles and responsibilities pertaining to assignment and creation of user licenses are outlined in *Section 1: Roles and Responsibilities*.

Each user must have a unique user ID and password, which is provided through the System Administrator upon completion of training. The user will be asked to establish a new password at initial log-in. Passwords are the individual's responsibility and must meet minimum system requirements, be kept secure, and be difficult to guess. **Users are prohibited from sharing user IDs or passwords.** If a user forgets their password or is locked out after multiple failed attempts, they may use the 'forgot password' feature in HMIS or contact the HMIS Help Desk for support, nilhmis.cayzu.com/.

Passwords will expire every 45 days and users will be prompted upon log-in to reset their password. If a user has not logged into the system for more than 30 days, their account will be inactivated, and they will need to contact the HMIS Help Desk for support, nilhmis.cayzu.com/.

Virus Protection

All devices directly accessing the HMIS and any device that is on a network that has a device directly accessing the HMIS must have industry compliant virus protection software installed. Both Operating System updates and virus definitions must be set to be updated and applied automatically. The virus protection software must also include anti-spyware functionality. Operating Systems must be supported by their vendors. Virus scans must be completed at least weekly.

Firewalls

An agency must protect the HMIS and client data from malicious intrusion behind a secure and up-to-date firewall. Each individual device does not need its own firewall if there is a firewall between that device and any systems, including the Internet and other computer networks, located outside of the organization. For example, a device that accesses the Internet through a modem, public Wi-Fi or cellular data network would need its own firewall. A device that accesses the Internet through a central server would not need a firewall if the server has a firewall. Firewalls are commonly included with all new operating systems.

Physical Access

All computers and devices must be controlled through physical security measures and/or a password.

Users must logoff from the HMIS and their device if they leave their workstation. The HMIS System automatically logs users off after 30 minutes of inactivity. When devices are not in use, a password protected screensaver or lock screen should automatically turn on within 15 minutes of inactivity. Users on mobile devices or working in outreach locations in addition to system administrators are encouraged to decrease this time to 5 minutes.

Users should be trained on how to quickly lock their computer or device if they need to step away. On windows workstations, this is achieved by typing the command “Windows Key + L.” Different operating systems have different locking mechanisms.

If users are going to be away from the computer or device for an extended period of time, they are encouraged to shut down the computer or device. Users should follow their agency’s “shut-down procedures” to ensure proper device, network, and virus updates.

Disposal

Agency policies, consistent with applicable state and federal laws, should be established regarding appropriate locations for storage, transmission, use and disposal of HMIS generated hardcopy or digital data. Reasonable care should be used, and media should be secured when left unattended. Magnetic media containing HMIS data which is released and/or disposed of from the participating organization and central server should first be processed to destroy any data residing on that media. Degaussing and overwriting are acceptable methods of destroying data.

System Monitoring

The HMIS maintains a permanent audit trail that tracks user log-in attempts and modifications to client records. Each audit entry reflects the user that created the entry and the date and name of the user that made the most recent modification.

These user logs will be checked routinely according to best practices established by the HMIS Lead Agency. Possible mechanisms the HMIS Lead may utilize are comparing the volume of search records accessed compared to the size of the agency, looking for multiple user logins from multiple locations, client searches occurring without record adjustment, users logging into the system at strange times and looking at the frequency of user password reset and logout.

Hard Copy Data

Printed versions (hardcopy) of confidential data should not be left unattended and open to compromise. Media containing HMIS client identified data may not be shared with any person or agency other than the owner of the data for any reason not disclosed within the agency’s Privacy Notice.

HMIS information in hardcopy format should be disposed of properly. This may include shredding finely

enough to ensure that the information is unrecoverable.

Software Application Security

Disaster Recovery

The Northern Illinois (NIL) HMIS Technical Lead Agency is responsible for ensuring that its vendors meet all regulated Disaster Protection and Recovery requirements. NIL HMIS is covered under WellSky's 'Basic Disaster Recovery Plan'.

Electronic Data Transmission

The NIL HMIS Technical Lead Agency is responsible for ensuring that its vendors meet all regulated Electronic Data Transmission requirements.

Electronic Data Storage

The NIL HMIS Technical Lead Agency is responsible for ensuring that its vendors meet all regulated Electronic Data Storage requirements.

Workstation Minimum Requirements

Any computer that interfaces with the HMIS must meet the minimum specifications or functionality cannot be guaranteed. Three main factors that can impact system performance are data transfer efficiency, memory management, and machine speed. Currently, the requirements are as follows:

- Operating System - Windows 8 and 10
- Memory - 2GB RAM minimum, 4GB recommended
- Monitor - Screen Display - 1024 x 768 (XGA)
- Processor - Dual-Core processor
- Internet Connection - Broadband
- Internet Browsers in order of compatibility: Google Chrome, Mozilla Firefox, Internet Explorer, Apple Safari.

There may be additional requirements for report creation.

Computer Crime

Computer crimes violate state and federal law. They include but are not limited to: unauthorized disclosure, modification or destruction of data, programs or hardware; theft of computer services; illegal copying of software; invasion of privacy; theft of hardware, software, peripherals, data or printouts; misuse of communication networks; promulgation of malicious software such as viruses; and breach of contract. Perpetrators may be prosecuted under state or federal law, held civilly liable for their actions, or both. The System Administrator and users must comply with license agreements for copyrighted software and documentation. Licensed software must not be copied unless the license agreement specifically provides for it. Copyrighted software must not be loaded or used on systems for which it is not licensed. All users agree to this upon logging into the system for the first time and accepting the

software's *End User License Agreement*.

Illinois Personal Information Protection Act

As discussed in **Section One** of this standard operating procedure, all agencies and users are bound to follow state and federal law and following those laws precede following this standard operating procedure. The steps outlined here are requirements of HMIS System Participation and should not be considered legal advice.

The Illinois Personal Information Protection Act (815 ILCS 530/5)⁶ requires that data collectors who maintain Social Security numbers take sufficient measures to ensure the security of the data and to notify Illinois Residents if a data breach occurs. The collection of Social Security numbers is a mandatory requirement of HUD's minimum data collection requirements and thus both individual agencies as well as the HMIS are "Data Collectors" and are bound to the law. A client may be notified multiple times by each level of 'data holding' (HMIS Vendor, HMIS Lead, and individual agencies).

If a Breach Occurs at the Individual Agency

Upon detection of a breach of the security of the agency's data, the agency's Executive Director or Agency Data Administrator, must take the following actions:

1. Notification will be made to all Continuum of Care Contacts as listed on the HMIS website, dupageco.org/HMIS/Forms.
2. Notification will be made to individual agency clients in **one** of the following ways
 - a. Written notice
 - b. Electronic notice, if the notice provided is consistent with the provisions regarding electronic records and signatures for notices legally required to be in writing as set forth in section 7001 of title 15 of the united states code⁷; or
 - c. Substitute notice, if the data collector demonstrates that the cost of providing notice would exceed \$250,000 or that the affected class of subject persons to be notified exceeds \$500,000, or the data collector does not have sufficient contact information. Substitute notice shall consist of all the following:
 - i. Email notice if the data collector has an email address for the subject persons;
 - ii. Conspicuous posting of the notice on the data collector's web site page if the data collector maintains one; and
 - iii. Notification to major statewide media

⁶ <http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=2702&ChapterID=67>

⁷ <http://www.gpo.gov/fdsys/pkg/USCODE-2011-title15/pdf/USCODE-2011-title15-chap96-subchapl-sec7001.pdf>

If Breach Occurs at a System Level

Upon detection of a breach of the security of the system data, the HMIS Lead must take the following actions:

1. Notification will be made to all Continuum of Care Contacts as listed on the HMIS website, dupageco.org/HMIS/Forms.
2. Notify each participating agency's Agency Data Administrator and Executive Director
3. The HMIS does not maintain adequate records for individual notification if a breach occurs (current address, phone number or email address). Provide a substitute notification by completing all the following:
 - a. Email Notice when an email address is available
 - b. Conspicuous Posting to be added to the HMIS website
 - c. Press Release to major statewide media

In either situation, the notice(s) must contain the following information:

1. The actual or approximate date of the security breach
2. The nature of the breach
3. A description of the steps that have or will be taken to address the breach
4. Toll-free number and address for each major consumer reporting agency and the Federal Trade Commission
5. Include a statement informing the individual that they can obtain information from each of the consumer reporting agencies about fraud alerts and security freezes.

Contact	Website	Phone	Address
Equifax	equifax.com/personal/credit-report-services	800-685-1111	PO Box 740241 Atlanta, GA 30374
Transunion	transunion.com/credit-help	888-909-8872	PO Box 2000, Chester, PA 19022-2000
Experian	experian.com/help	888-EXPERIAN (888-397-3742)	P.O. Box 4500, Allen, TX 75013
Federal Trade Commission	ftccomplaintassistant.gov	877-FTC-HELP (877-382-4357)	600 Pennsylvania Ave., NW, Washington DC 20580

Forms

Refer to dupageco.org/HMIS/Forms for a full list of available forms or select the form listed below to download a copy.

- I. Agreements
 - a. Program Partner
 - b. Agency Data Administrator
 - c. End User
- II. Privacy Forms
 - a. Baseline Privacy Form
 - b. Privacy Posting
 - c. Acknowledgement of Receipt
 - d. Refusal Form
 - e. NIL Participating Agencies
 - f. Data Sharing Summary
- III. Security Breach Sample Letter
- IV. Universal Intake Forms
 - a. Intake
 - b. Update
 - c. Exit
 - d. Current Living Situation



**HMIS Partner Agreement between
DuPage County Community Services
and
[Agency Name]**

This agreement is entered into on _____ (MM/DD/YY) between DuPage County Community Services, hereafter known as "HMIS LEAD" and _____ (agency name), hereafter known as "AGENCY," regarding access and use of the Homeless Management Information System, hereafter known as "HMIS."

I. Introduction

The HMIS, a shared human services database, allows authorized personnel at homeless and human service provider agencies throughout DuPage and Suburban Cook Counties Continuum of Care, to enter, track, and report on information concerning their own clients and to share information, subject to appropriate inter-agency agreements, on common clients.

In compliance with all state and federal requirements regarding client/consumer confidentiality and data security, the HMIS is designed to collect and deliver quality data about services and homeless persons or persons at risk for being homeless and meet the reporting requirements of the U.S. Department of Housing and Urban Development (HUD), and other funders as needed. DuPage County Community Services and The Alliance to End Homelessness of Suburban Cook County partner together to administer the HMIS for the DuPage County Continuum of Care.

II. HMIS LEAD Responsibilities

1. The HMIS LEAD will make a best effort to provide the AGENCY 24 hour access to the HMIS database system, except during routine system maintenance, scheduled system upgrades and unexpected system failures.
2. The HMIS LEAD will provide model Privacy Notices, Client forms and other templates for agreements that may be adopted or adapted in local implementation of HMIS functions.
3. The HMIS LEAD will provide both initial training and periodic updates for all end-users regarding the use of the HMIS.
4. The HMIS LEAD will provide basic user support and technical assistance (i.e., general trouble-shooting and assistance with standard report generation).

III. AGENCY Responsibilities

1. The AGENCY agrees to abide by the most current *HMIS Standard Operating Procedure* (Policy) approved and adopted by the DuPage County Continuum of Care, which is incorporated into this agreement by reference and may be modified from time to time at the DuPage County Continuum of Care's discretion. The Policy includes privacy, security, and data entry requirements. If any item in this agreement differs from the Policy, the Policy shall prevail.
2. The AGENCY agrees to ensure that all employees and agents comply with the Policy.
3. The AGENCY agrees to ensure staffing and equipment necessary to implement and ensure HMIS participation.
4. The *HMIS Standard Operating Procedure* can be obtained online at www.dupageco.org/hmis.
5. The AGENCY agrees to designate an AGENCY DATA ADMINISTRATOR that will act as the agency's key point person in communicating with the HMIS LEAD. This person is to be designated in writing by the Chief Executive Officer, Executive Director or equivalent of the AGENCY.

IV. Privacy and Confidentiality

A. Protection of Client Privacy

1. The AGENCY will comply with all applicable federal and state laws regarding protection of client privacy.
2. The AGENCY will comply with all policies and procedures established by the HMIS LEAD pertaining to protection of client privacy.

B. Client Confidentiality

1. The AGENCY agrees to make available a copy of the *AGENCY'S Privacy Notice* (or an equivalent AGENCY-specific alternative) to each consumer. The AGENCY will provide a verbal explanation of the HMIS and arrange for a qualified interpreter/translator or other reasonable accommodation in the event that an individual is not literate in English or has difficulty understanding the *AGENCY'S Privacy Notice* and/or associated consent form(s).
2. The AGENCY will solicit or enter information about clients into the HMIS database only in order to provide services or conduct evaluation or research. AGENCY management, in consultation with the HMIS LEAD, will make a determination of what qualifies as essential for services or research.
3. The AGENCY will divulge any information received from the HMIS to any organization or individual only with proper written consent from the client, unless otherwise permitted by applicable regulations or laws, including exceptions outlined in AGENCY's Privacy Notice.
4. The AGENCY will ensure that all persons who are issued a User Identification and Password to the HMIS abide by this *HMIS Partner Agreement*, including all associated confidentiality provisions. The AGENCY will be responsible for oversight of its own related confidentiality requirements.
5. The AGENCY acknowledges that maintaining the confidentiality, security and privacy of information downloaded from the system by the AGENCY is strictly the responsibility of the AGENCY.

C. Inter-Agency Sharing of Information

1. The AGENCY acknowledges that all forms provided by the HMIS LEAD regarding client privacy and confidentiality are shared with the AGENCY as generally applicable models that may require specific modification in accord with AGENCY-specific rules. The AGENCY will review and revise (as necessary) all forms provided by the HMIS LEAD to assure that they are in compliance with the laws, rules and regulations that govern its organization.
2. The AGENCY acknowledges that client notification as defined by the Policy is required before any basic identifying client information is shared with other agencies in the System.
3. If the AGENCY intends to share restricted client data within the HMIS, the AGENCY will execute an HMIS data sharing agreement with each Agency with whom the restricted data is to be shared. Restricted information, including progress notes and psychotherapy notes, about the diagnosis, treatment, or referrals related to a mental health disorder, drug or alcohol disorder, HIV/AIDS, and domestic violence concerns shall not otherwise be shared with other participating Agencies. Agencies with whom restricted information is shared are each responsible for obtaining appropriate consent(s) before allowing further sharing of client records.
4. The AGENCY acknowledges that the AGENCY, itself, bears primary responsibility for oversight for all sharing of data it has collected via the HMIS. The HMIS LEAD will hold the AGENCY responsible only for information that the AGENCY shares. The HMIS LEAD however, will not hold the AGENCY responsible for the actions of the Entity that receives and misappropriates the shared data; unless the AGENCY knew or should have known that the Entity would misappropriate or were otherwise not entitled to receive the shared information.

D. Custody of Data

If this Agreement is terminated, AGENCY will no longer have access to the HMIS. The HMIS LEAD shall make reasonable accommodations to assist the AGENCY to export their data in a format that is usable in their alternative database. Any costs associated with exporting the data will be the sole responsibility of the AGENCY.

V. Hold Harmless

1. The HMIS LEAD makes no warranties, expressed or implied. The AGENCY, at all times, will indemnify and hold the HMIS LEAD harmless from any damages, liabilities, claims, and expenses that may be claimed against the AGENCY; or for injuries or damages to the AGENCY or another party arising from participation in the HMIS; or arising from any acts, omissions, neglect, or fault of the AGENCY or its agents, employees, licensees, or clients; or arising from the AGENCY 's failure to comply with laws, statutes, ordinances, or regulations applicable to it or the conduct of its business. This AGENCY will also hold the HMIS LEAD harmless for loss or damage resulting in the loss of data due to delays, non-deliveries, deliveries in error, or service interruption

caused by the HMIS software vendor, by the AGENCY's or other member agency's negligence or errors or omissions, as well as natural disasters or technological difficulties, and/or any other cause not under the reasonable control of the HMIS lead. The HMIS LEAD shall not be liable to the AGENCY for damages, losses, or injuries to the AGENCY or another party other than if such is the result of gross negligence or willful misconduct of the HMIS LEAD. The HMIS LEAD agrees to hold the AGENCY harmless from any damages, liabilities, claims or expenses caused solely by the negligence or misconduct of the HMIS LEAD.

2. Provisions of Section V shall survive any termination of the *HMIS Partner Agreement*. All restrictions on the use and disclosure of client information will also survive any termination of the *HMIS Partner Agreement*.

VI. Terms and Conditions

1. The parties hereto agree that this agreement is the complete and exclusive statement of the agreement between parties and supersedes all prior proposals and understandings, oral and written, relating to the subject matter of this agreement.
2. The Agency shall not transfer or assign any rights or obligations under the *HMIS Partner Agreement* without the written consent of the HMIS LEAD.
3. This agreement shall remain in force until revoked in writing by either party, with 30 days advance written notice. The exception to this term is if allegations or actual incidences arise regarding possible or actual breeches of this agreement. Should such situations arise, the HMIS LEAD may immediately suspend access to the HMIS until the allegations are resolved in order to protect the integrity of the system.
4. This agreement may be modified or amended by written agreement executed by both parties with 30 days advance written notice.

IN WITNESS WHEREOF, the parties have entered into this Agreement:

AGENCY:

HMIS LEAD:

Signature:

Signature:

Printed Name:

Printed Name:

Title: _____

Title: _____

Date: _____

Date: _____

Homeless Management Information System

ASSURANCE

_____ (Name of Agency) assures that the following fully executed documents will be on file and available for review.

- The AGENCY's official *Privacy Notice* for HMIS clients.
- Executed End User Agreement for each AGENCY user of the HMIS.
- Current copy of the *HMIS Standard Operating Procedure*.

By: _____

Title: _____

Signature: _____

Date: _____



HMIS Agency Data Administrator Policy and Code of Ethics

Agency Data Administrator Name (Please Print)

Responsibilities of each Agency Data Administrator

The Executive Director of each Participating Agency will appoint a qualified person as the Agency Data Administrator, who will need to ensure participation in all Agency Data Administrator trainings.

The Agency Data Administrator will be responsible for:

(Initial each line below)

	Acting as the key point-person with all information regarding HMIS and their designated agency.
	Attending and participating in all required site visits and sharing information with necessary staff to ensure that the agency is effectively and properly utilizing the HMIS.
	Reviewing and coordinating with HMIS System Administrators to update agency information in the HMIS database.
	Managing technical access to HMIS for authorized persons
	Notifying HMIS Staff of user changes as soon as possible, at minimum 24 hours after their occurrence
	Training new staff persons on the uses of the DuPage County Continuum HMIS including review of the SOPs in this document and any agency policies which impact the security and integrity of client information
	Ensuring that unsupervised access to the DuPage County Continuum HMIS be granted to authorized staff members only after they have received training and satisfactorily demonstrated proficiency in use of the software and understanding of the SOPs and agency policies referred to above
	Notifying all users in their agency of interruptions to service
	Generating reports for agency specific data, when needed. This includes reviewing reports to ensure data integrity, data quality, full reporting of HUD Minimum Data Requirements & other data required by the agency to complete reports, etc.
	Attending training to ensure ongoing understanding of the development of the HMIS, improved technical reporting capabilities, system updates, etc.
	Implementing an Agency data security policy and standards, including: <ul style="list-style-type: none"> ▪ Administering agency-specified business and data protection controls ▪ Administering and monitoring of access control ▪ Detecting and responding to violations of the SOPs or agency procedures

Acknowledgement

I acknowledge that I have read the responsibilities of the Agency Data Administrator and certify that I can perform these functions.

_____ Agency

_____ Agency Data Administrator Signature

_____ Date



HMIS End User Policy and Code of Ethics

HMIS User Name (Please Print)

USER POLICY

Partner Agencies who use the Northeast Illinois Homeless Management Information System (HMIS) and each User within any Partner Agency is bound by various restrictions regarding Protected Personal Information ("PPI"). The employee, contractor, or volunteer whose name appears above is the **User**.

It is a **Client's** decision about what level of information is to be shared with any Partner Agencies. If your agency is covered by HIPAA or 42 CFR Part 2 (federally-defined treatment facility), it is also Client's decision about whether this Agency or Northeast Illinois HMIS may use information for research purposes, unless certain other approvals have been obtained.

Before any PPI is designated for sharing, the User shall ensure that the agency's HMIS Notice of Privacy Practices was fully reviewed with Client in a manner to ensure that Client fully understood the information. Any PPI not covered in the HMIS Notice of Privacy Practices must be covered by a signed client consent prior to sharing.

USER PRINCIPLES

A User ID and Password gives you access to the Northeast Illinois HMIS. **You must initial each item below** to indicate your understanding and acceptance of the proper use of your ID and password. Failure to uphold the confidentiality standards set forth below is grounds for your immediate termination from the HMIS.

(Initial each line below)

	I understand that I have an obligation to maintain Client privacy and to protect and safeguard the confidentiality of Client's PPI. PPI shall include, but not be limited to, the Client's name, address, telephone number, social security number, type of medical care provided, medical condition or diagnosis, veteran status, employment information, and any and all other information relating to the Client's programming.
	My User ID and Password are for my use only and must not be shared with anyone, including my supervisor(s). I must take all reasonable means to keep my Password physically secure.
	I understand that the only individuals who can view information in the HMIS are authorized users who need the information for legitimate business purposes of this Agency and the Clients to whom the information pertains.
	I may only view, obtain, disclose, or use information within the HMIS that is necessary to perform my job.
	If I am logged into the HMIS and must leave the work area where the computer is located, I must logoff before leaving the work area.
	Any hard copies of PPI printed from the HMIS must be kept in a secure file, and destroyed when no longer needed, in accordance with Agency's records retention policy. I will not leave hard copies of PPI in public view on my desk, or on a photocopier, printer, or fax machine.
	I will not discuss PPI with anyone in a public area.
	I have reviewed the Agency's HMIS Notice of Privacy Practices and the <i>HMIS Standard Operating Procedures</i> , understand each of those documents, and agree to abide by them.
	If I notice or suspect a security breach, I must immediately notify the Agency Data Administrator or Executive Director, if Agency Data Administrator is unavailable or if the Executive Director is otherwise the most appropriate contact. The Agency Data Administrator and Executive Director are responsible for taking action as instructed in the Standard Operating Procedures.
	I understand that any violation of this Agreement can lead to the suspension of my system access, and notification of such will be sent to my Employer.



HMIS End User Policy and Code of Ethics

USER CODE OF ETHICS

- A. Users must be prepared to answer Client questions regarding the HMIS.
- B. Users must respect Client preferences with regard to the sharing of PPI within the HMIS. Users must accurately record Client's preferences by making the proper designations as to sharing of PPI and/or any restrictions on the sharing of PPI.
- C. Users must allow Client to change his or her information sharing preferences at the Client's request (*i.e.*, to revoke consent) (except if that policy is over-ridden by Agency policy or if the information is required to be shared as a condition of a provider agreement).
- D. Users must not decline services to a Client or potential Client if that person refuses to share his or her personal information with other service providers via the HMIS (except if that policy is over-ridden by Agency policy or if the information is required to be shared as a condition of a provider agreement).
- E. The User has primary responsibility for information entered by the User. Information Users enter must be truthful, accurate and complete to the best of User's knowledge.
- F. Users will follow the Standard Workflow, answering all Universal and Program Specific Data Elements as described by local and Federal HMIS policies.
- G. Users will not solicit from or enter information about Clients into the HMIS unless the information is required for a legitimate business purpose such as to provide services to the Client.
- H. Users will not include profanity or offensive language in the HMIS; nor will Users use the HMIS database for any violation of any law, to defraud any entity or conduct any illegal activity.

PASSWORD PROCEDURES

By signing this Agreement, you agree to the following:

Passwords are your responsibility and you may not share passwords. They should be securely stored and inaccessible to other persons—including your supervisor(s). Passwords should never be stored or displayed in any publicly accessible location and should not be transmitted electronically without the DuPage System Administrator's permission.

USER GRIEVANCE PROCEDURE

If you have a grievance with this Code of Ethics, you may send a written complaint to this Agency.

If your complaint is not resolved to your satisfaction, you may send your written complaint to:
DuPage County HMIS, 421 N County Farm Road, Wheaton, IL 60187, Attn: HMIS System Administrator.

I understand and agree to comply with the above User Policy, User Principles, User Code of Ethics, Password Procedures, and User Grievance Procedure.

HMIS User Signature	Date
HMIS User Login (Username)	
Email Address	
Agency/System Administrator Signature	Date

[AGENCY] PRIVACY NOTICE

Effective (05/01/2015)

Version 3.0

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. What This Notice Covers

1. This notice describes the privacy policy and practices of [Name of Agency]. Our main office is at [Address, web address, telephone contact information].
2. A client is anyone whose personal data is included in the Northeast Illinois HMIS [in connection with the receipt of services or assistance]. This person need not be homeless.
3. When a client request services from this agency, we enter information about them and members of their household into a computer system called a Homeless Management Information System (HMIS). This HMIS is used by many agencies in Suburban Cook and DuPage Counties that provide services to persons and families in need.
4. The HMIS is administered by DuPage County Department of Community Services. Their office is at 421 N County Farm Road, Wheaton, IL 60187. Their website is www.dupageco.org/HMIS. You can contact the system administrator at 630-407-6397. DuPage County Department of Community Services has adopted this Privacy Notice as well.
5. The policy and practices in this notice cover the processing of protected personal information of those agencies participating in the Northeast Illinois Homeless Management Information System (HMIS). All personal information that we maintain, not just the information entered into the HMIS, is covered by the policy and practices described in this notice. This policy covers only the programs within the agency that participate in HMIS.
6. Protected Personal information (PPI) is any information we maintain about a client that:
 - a. allows identification of an individual directly or indirectly
 - b. can be manipulated by a reasonably foreseeable method to identify a specific individual, **or**
 - c. can be linked with other available information to identify a specific client.When this notice refers to personal information, it means PPI.
7. We adopted this policy because of standards for Homeless Management Information Systems issued by the Department of Housing and Urban Development. We intend our policy and practices to be consistent with those standards. See 69 Federal Register 45888 (July 30, 2004).
8. This notice tells our clients, our staff, and others how we process personal information. We follow the policy and practices described in this notice.
9. We may amend this notice and change our policy or practices at any time. Amendments may affect personal information that we obtained before the effective date of the amendment. All amendments are approved by the HMIS Committee of the DuPage County Continuum of Care and are then adopted by all agencies that use the HMIS.

Current information about the DuPage County HMIS Committee can be found on the HMIS website at www.dupageco.org/HMIS.

10. We give a written copy of this privacy notice to any individual who asks. We maintain a copy of this policy on the HMIS website at www.dupageco.org/HMIS.

B. How and Why We Collect Personal Information

1. We collect personal information only when appropriate to provide services or for another specific purpose of our agency or when required by law.
2. We may collect personal information for these purposes:
 - a. To provide or coordinate services to clients
 - b. To locate other programs that may be able to assist clients
 - c. To verify information given to us by clients
 - d. For functions related to payment or reimbursement from other services that we provide
 - e. To operate our agency, including administrative functions such as legal, audits, personnel, oversight, and management functions
 - f. To comply with reporting obligations
 - g. When required by law
3. We may be required to collect some personal information by law or by organizations that give us money to operate this program. Other personal information that we collect is important to run our programs, to improve services, and to better understand the need individuals in the community. We only collect information that we consider to be appropriate.
4. We only use lawful and fair means to collect personal information.
5. We normally collect personal information with the knowledge or consent of our clients. If you seek our assistance and provide us with personal information, we assume that you consent to the collection of information as described in this notice.
6. We may also get personal information from:
 - a. Individuals who are with you or are part of your household
 - b. Individuals who are assisting you
 - c. Individuals or organizations you provide for verification of information or references
 - d. Information already collected about you by other agencies that are part of the HMIS
 - e. Other private organizations in the DuPage County Continuum of Care
 - f. Government agencies including DuPage County and the State of Illinois.
 - g. Public records including internet searches, telephone directories and other published sources
7. When possible, we post a sign at our intake desk or other location explaining the reasons we ask for personal information. The sign gives our agency's contact information, the HMIS administrator's contact information and the location of this privacy notice.

C. How We Use and Disclose Personal Information

1. We use or disclose personal information for activities described in this part of the notice. We may or may not make any of these uses or disclosures with your information. We share client records with other agencies that may have separate privacy policies and that may allow different uses and disclosures of the information.

2. All participating agencies of the Northeast Illinois HMIS share client record information. The information that is shared with these participating agencies is extensive. The list of these agencies and the information shared changes frequently. You can view a full list of these agencies and the information that we share at our website, www.dupageco.org/HMIS.
3. **You have the right to opt-out of having this information shared with other participating agencies.** To do so, you must request and sign the “Client Data Sharing Refusal Form.” If you sign this form, your information will remain in the HMIS and be subject to the other disclosures in this privacy notice, but the information will not be available to the other participating agencies of the Northeast Illinois HMIS.
4. The information that will be shared if you do not opt-out is as follows:
 - a. Personal identification information
 - b. Demographic information
 - c. Program Enrollment Type and Dates
 - d. The name of your case manager, if you are assigned one

The detailed list of information that we share can be found at our website:
www.dupageco.org/HMIS

5. Some programs and agencies require sharing of information different than what is discussed in this privacy notice. For those programs, individuals will be presented with additional consent information.
6. We assume that you consent to the use or disclosure of your personal information for the purposes described here and for other uses and disclosures that we determine to be compatible with these uses or disclosures:
 - a. to provide or coordinate services to individuals
 - b. for functions related to payment or reimbursement for services
 - c. to carry out administrative functions such as legal, audits, personnel, oversight, and management functions
 - d. to create de-identified (anonymous) information that can be used for research and statistical purposes without identifying clients
 - e. when required by law to the extent that use or disclosure complies with and is limited to the requirements of the law, including Freedom of Information Act requests
 - f. to avert a serious threat to health or safety if
 - (1) we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public, and
 - (2) the use or disclosure is made to a person reasonably able to prevent or lessen the threat, including the target of the threat
 - g. to report about an individual we reasonably believe to be a victim of abuse, neglect or domestic violence to a governmental authority (including a social service or protective services agency) authorized by law to receive reports of abuse, neglect or domestic violence
 - (1) under any of these circumstances:
 - (a) where the disclosure is required by law and the disclosure complies with and is limited to the requirements of the law
 - (b) if the individual agrees to the disclosure, or

- (c) to the extent that the disclosure is expressly authorized by statute or regulation, and
 - (I) we believe the disclosure is necessary to prevent serious harm to the individual or other potential victims, or
 - (II) if the individual is unable to agree because of incapacity, a law enforcement or other public official authorized to receive the report represents that the PPI for which disclosure is sought is not intended to be used against the individual and that an immediate enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.
- (2) when we make a permitted disclosure about a victim of abuse, neglect or domestic violence, we will promptly inform the individual who is the victim that a disclosure has been or will be made, except if:
 - (a) we, in the exercise of professional judgment, believe informing the individual would place the individual at risk of serious harm, or
 - (b) we would be informing a personal representative (such as a family member or friend), and we reasonably believe the personal representative is responsible for the abuse, neglect or other injury, and that informing the personal representative would not be in the best interests of the individual as we determine in the exercise of professional judgment.
- h. for academic research purposes
 - (1) conducted by an individual or institution that has a formal relationship with this agency if the research is conducted either:
 - (a) by an individual employed by or affiliated with the organization for use in a research project conducted under a written research agreement approved in writing by a designated agency program administrator (other than the individual conducting the research), or
 - (b) by an institution for use in a research project conducted under a written research agreement approved in writing by a designated agency program administrator.
 - (2) any written research agreement:
 - (a) must establish rules and limitations for the processing and security of PPI in the course of the research
 - (b) must provide for the return or proper disposal of all PPI at the conclusion of the research
 - (c) must restrict additional use or disclosure of PPI, except where required by law
 - (d) must require that the recipient of data formally agree to comply with all terms and conditions of the agreement, and
 - (e) is not a substitute for approval (if appropriate) of a research project by an Institutional Review Board, Privacy Board or other applicable human subjects protection institution.
- i. to a law enforcement official for a law enforcement purpose (if consistent with applicable law and standards of ethical conduct) under any of these circumstances:
 - (1) in response to a lawful court order, court-ordered warrant, subpoena or summons issued by a judicial officer, or a grand jury subpoena

- (2) if the law enforcement official makes a written request for PPI that:
 - (a) is signed by a supervisory official of the law enforcement agency seeking the PPI
 - (b) states that the information is relevant and material to a legitimate law enforcement investigation
 - (c) identifies the PPI sought
 - (d) is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought, and
 - (e) states that de-identified information could not be used to accomplish the purpose of the disclosure.
 - (3) if we believe in good faith that the PPI constitutes evidence of criminal conduct that occurred on our premises
 - (4) in response to an oral request for the purpose of identifying or locating a suspect, fugitive, material witness or missing person and the PPI disclosed consists only of name, address, date of birth, place of birth, Social Security Number, and distinguishing physical characteristics, or
 - (5) the official is an authorized federal official seeking PPI for the provision of protective services to the President or other persons authorized by 18 U.S.C. 3056, or to foreign heads of state or other persons authorized by 22 U.S.C. 2709(a)(3), or for the conduct of investigations authorized by 18 U.S.C. 871 and 879 (threats against the President and others), and the information requested is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought.
 - j. to comply with reporting obligations for homeless management information systems and for oversight of compliance with homeless management information system requirements.
 - k. to the administrators and contractors of the HMIS system, including DuPage County and Suburban Cook County Staff and contractors, Bowman Systems, L.L.C staff and contractors and the HMIS Committee Chairperson and vice-Chairperson.
7. Before we disclose your personal information that is not described here, we seek your consent first.

D. How to Inspect and Correct Personal Information

1. You may inspect and have a copy of your personal information that we maintain. We will offer to explain any information that you may not understand.
2. We will consider a request from you for correction of inaccurate or incomplete personal information that we maintain about you. If we agree that the information is inaccurate or incomplete, we may delete it or we may choose to mark it as inaccurate or incomplete and to supplement it with additional information.
3. To inspect, get a copy of, or ask for correction of your information, ask a program staff member how to obtain this information.
4. We may deny your request for inspection or copying of personal information if:
 - a. the information was compiled in reasonable anticipation of litigation or comparable proceedings
 - b. the information is about another individual (other than a health care provider or homeless provider)
 - c. the information was obtained under a promise or confidentiality (other than a promise from a health care provider or homeless provider) and if the disclosure would reveal the source of the information, **or**

- d. disclosure of the information would be reasonably likely to endanger the life or physical safety of any individual.
5. If we deny a request for access or correction, we will explain the reason for the denial. We will also include, as part of the personal information that we maintain, documentation of the request and the reason for the denial
6. We may reject repeated or harassing requests for access or correction.

E. Data Quality

1. We collect only personal information that is relevant to the purposes for which we plan to use it. To the extent necessary for those purposes, we seek to maintain only personal information that is accurate, complete, and timely.
2. We are developing and implementing a plan to dispose of personal information, found in the HMIS system, not in current use seven years after the information was created or last changed. As an alternative to disposal, we may choose to remove identifiers from the information.
3. We may keep information for a longer period if required to do so by statute, regulation, contract, or other requirement.

F. Complaints and Accountability

1. We accept and consider questions or complaints about our privacy and security policies and practices. Because there are many agencies and parties involved, it is often hard to know where to direct a complaint. We ask that questions or complaints regarding the HMIS go to the HMIS System Administrator at DuPage County Community Services. Questions or complaints pertaining to the agency serving you should follow the agency's grievance procedure. If you are unsure where to go, you may go to either agency listed below and we will help you determine the best person to speak with.

HMIS System Administrator

421 N County Farm Road

Wheaton, IL 60187

630-407-6397

www.dupageco.org/HMIS

[Agency Contact Information]

[Address]

[Address]

[Phone Number]

[Website]

2. All members of our staff (including employees, volunteers, affiliates, contractors and associates) are required to comply with this privacy notice. Each staff member must receive and acknowledge receipt of a copy of this privacy notice.

G. Change History:

1. Version 1.0 October 2009- Initial Policy was a part of client consent documents
2. Version 2.0 October 2012 - Adopted HUD's baseline privacy notice and detailed our implied consent disclosure process
3. Version 3.0 October 2014 – Updated HUD's baseline privacy notice to include Suburban Cook County, address the name change of DuPage County HMIS to Northeast Illinois HMIS, and reflect the changes to the list of shared data elements.



DuPage County Homeless Management Information System

This posting summarizes how information about you may be used and disclosed and how you can get access to this information.

Agency use of your information	<ul style="list-style-type: none">• We collect personal information for reasons that are discussed in our Privacy Notice.• We may be required to collect some personal information by law or by organizations that give us money to operate this program.• Other personal information that we collect is important to run our programs, to improve services, and to better understand the need individuals in the community.• We only collect information that we consider to be appropriate.• We assume that you consent to the use or disclosure of your personal information as described in the Privacy Notice.
Your rights and choices	<ul style="list-style-type: none">• You have the right to request a copy of the Privacy Notice and have your questions answered.• You have the right to refuse to answer any question we ask, though this may impair our ability to provide the services you are requesting.• You have the right to opt-out of having your information shared with other agencies by requesting and signing the “Client Data Sharing Refusal Form.”
Contact information	<p data-bbox="667 1286 1020 1323" style="text-align: center;">[Agency Contact Info]</p> <p data-bbox="1276 1177 1995 1427">DuPage County HMIS System Administrator 421 N County Farm Road Room 3-100 Wheaton, IL 60187 www.dupageco.org/HMIS 630-407-6397</p>

To read the full Privacy Notice, ask for a copy or visit
[\[www.dupageco.org/HMIS\]](http://www.dupageco.org/HMIS)

ACKNOWLEDGEMENT OF RECEIPT
Notice of [Agency's] Privacy Notice

[This Agency] is required to maintain a Privacy Notice. The Privacy Notice describes the information we collect, how we manage that information and your rights and choices pertaining to that information.

[This Agency] participates in a Homeless Management Information System (HMIS) along with many other agencies. Unless you request and sign the “Client Data Sharing Refusal Form,” much of your information will be shared with these other agencies for the purposes disclosed in the Privacy Notice. The information shared is discussed in the Privacy Notice.

If you would like a copy of the Privacy Notice or would like to request the “Client Data Sharing Refusal Form,” please ask.

Refusing to sign this acknowledgement does not prevent us from using or disclosing your information. In order to prevent disclosure of your information to, you must request and sign the “Client Data Sharing Refusal Form.” If you refuse to sign this acknowledgement, we will keep a record that you refused to sign the acknowledgement but that you were informed of our Privacy Notice.

I HAVE REVIEWED THE ABOVE INFORMATION AND I CONFIRM THAT:

- I was offered a copy of [This Agency’s] Privacy Notice.
- I have reviewed [This Agency’s] Privacy Notice. I was given the option to have this document and the Privacy Notice read to me.
- I have had the opportunity to ask questions about [This Agency’s] Privacy Notice and about how information about me and my family will be shared with other agencies who participate in the HMIS.
- I was given the option to request and sign the “Client Data Sharing Refusal Form.”
- I understand that services cannot be denied to me because of my refusal to share my information.

Name of Client or Guardian

Signature of Client or Guardian

Date

CLIENT DATA SHARING REFUSAL FORM

I hereby opt-out and/or revoke permission for [Agency Name] to share my personal and household information with other agencies in the DuPage County Homeless Management Information System (HMIS).

However, all information that I provide will remain in the HMIS for the purposes disclosed in the Privacy Notice. This information will be accessible to the HMIS system administrators and disclosure may still occur in accordance with the Privacy Notice.

Information already in the database system will continue to be shared with other agencies.

Members of this household who's information are not to be shared:

Name	HMIS Number

Name of Client or Guardian

Signature of Client or Guardian

Date

To be filled out by Agency:

___ I certify that I followed the necessary steps to ensure the client's HMIS profile was set up correctly

OR

___ I contacted the DuPage County HMIS Help Desk to request set up of the client's HMIS profile.

Staff Name

Signature

Date

DuPage County CoC HMIS Data Sharing Summary

An updated list of Northeast Illinois Homeless Management Information System (HMIS) participating agencies are available at, suburbancook.org/hmis/agencies.

Information Shared to all Participating Agencies

Full Name & Alias
Date of Birth
Social Security Number
Gender
Race
Ethnicity
Household Relationships
Veteran Status
Photograph

Information Shared to DuPage County CoC Agencies

Primary Language Spoken
Name of Program Enrolled In
Program Enrollment Dates
Reason for Leaving the Program
Housing Destination After leaving the Program

Sample Security Breach Notification Letter

Date

Dear Recipient Name:

We are contacting you because we have learned of a serious data security incident that occurred on (specific or approximate date) *OR* between (date, year *and* date, year) that involved some of your personal information.

The breach involved (*provide a brief general description of the breach*). The information breached contained (*names, mailing addresses, and Social Security numbers, etc.*).

We are notifying you so you can take action along with our efforts to minimize or eliminate potential harm. [*describe action being taken*] Due to the serious nature of this incident, we strongly encourage you to take preventive measures to help prevent and detect any misuse of your information.

As a first preventive step, we recommend you closely monitor your financial accounts. If you see any unauthorized activity, promptly contact your financial institution. We also suggest you submit a complaint with the Federal Trade Commission, <https://www.identitytheft.gov/>, 600 Pennsylvania Avenue, NW, Washington, DC 20580, 877-FTC-HELP (877-382-4357).

As a second step, you also may want to contact the three U.S. credit reporting agencies (Equifax, Experian and TransUnion) to obtain a free credit report from each by calling 877-322-8228 or by logging onto www.annualcreditreport.com.

Even if you do not find any suspicious activity on your initial credit reports, the Federal Trade Commission (FTC) recommends that you check your credit reports periodically. A victim's personal information is sometimes held for use or shared among a group of thieves at different times. Checking your credit reports periodically can help you spot problems and address them quickly.

You will need to contact the three U.S. credit reporting agencies to place the security freeze. Keep in mind that when you place the freeze, you will not be able to borrow money, obtain instant credit, or get a new credit card until you temporarily lift or permanently remove the freeze.

To obtain a security freeze, contact the following agencies:

Experian
P.O. Box 4500
Allen, TX 75013
888-397-3742
www.experian.com

Equifax
PO Box 740241
Atlanta, GA 30374
888-685-1111
www.equifax.com

TransUnion
PO Box 2000
Chester, PA 19022-2000
888-909-8872
www.transunion.com

If you have further questions or concerns, you may contact the undersigned at this special telephone number, 000-000-0000. You can also check our website at www.ourwebsite.org for updated information.

Sincerely,

Name

Title

Agency

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		<input type="checkbox"/>	<input type="checkbox"/>
Last Name		Alias/Suffix		<input type="checkbox"/>	<input type="checkbox"/>
SSN			Approx. or Partial SSN Reported <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Veteran Status	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Veteran Status is on the Client Profile Tab and may need to be updated if the client is already in ServicePoint.</i>			<input type="checkbox"/>	<input type="checkbox"/>
Date of Birth			Approx. or Partial DOB Reported <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Primary Race	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> White		<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>
Secondary Race (Leave Blank if None)	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> White		<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other	NA	NA
Ethnicity	<input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Hispanic/Latino			<input type="checkbox"/>	<input type="checkbox"/>
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Transgender: M to F <input type="checkbox"/> Female <input type="checkbox"/> Transgender: F to M		<input type="checkbox"/> Doesn't identify as male, female or transgender	<input type="checkbox"/>	<input type="checkbox"/>
Primary Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish		<input type="checkbox"/> Other, specify:		

HOUSEHOLD INFORMATION

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

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

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.

<p>1A. Homeless Situation</p> <ul style="list-style-type: none"> <input type="checkbox"/> Place not meant for human habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) <input type="checkbox"/> Emergency Shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter <input type="checkbox"/> Safe Haven <p style="text-align: center;">↓ Next Answer 2A: Length of Stay. ↓</p>	<p>1B. Institutional Situation</p> <ul style="list-style-type: none"> <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 <p style="text-align: center;">↓ Next Answer 2B: Length of Stay. ↓</p>	<p>1C. Temporary or Permanent Housing Situation</p> <ul style="list-style-type: none"> <input type="checkbox"/> Residential or halfway house with no homeless criteria <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Host home (non-crisis) <input type="checkbox"/> Staying or living in a friend's room, apartment or house <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> Rental by client with GPD TIP housing subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons <input type="checkbox"/> Rental by client, with RRH or equivalent subsidy <input type="checkbox"/> Rental by client, with Housing Choice Voucher (HCV) (tenant or project based) <input type="checkbox"/> Rental by client in a public housing unit <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy <p style="text-align: center;">↓ Next Answer 2C: Length of Stay. ↓</p>
<p>2A: LENGTH OF STAY: <i>How long was the client in a Homeless Situation?</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> One Day or Less <input type="checkbox"/> Two Days to One Week <input type="checkbox"/> > One Week but < One Month <input type="checkbox"/> One to Three Months <input type="checkbox"/> > three months, but < 1 year <input type="checkbox"/> One Year or Longer <input type="checkbox"/> Client Does Not Know <input type="checkbox"/> Client Refused <p style="text-align: center;">↓ Next Answer 3: Chronic Questions ↓</p>	<p>2B: LENGTH OF STAY: <i>How long was the client in an Institutional Situation?</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> One Day or Less[Ⓕ] <input type="checkbox"/> Two Days to One Week[Ⓕ] <input type="checkbox"/> > One Week but < One Month[Ⓕ] <input type="checkbox"/> One to Three Months[Ⓕ] <input type="checkbox"/> > three months, but < 1 year <input type="checkbox"/> One Year or Longer <input type="checkbox"/> Client Does Not Know <input type="checkbox"/> Client Refused <p style="text-align: right; margin-right: 20px;">} 3 months or less</p> <p>[Ⓕ]<i>If the client reported <u>Three Months or less</u> then answer the question below. If the client reports more than 3 months, the client is not chronic, skip the rest of this page.</i></p> <p>On the night before the Institutional Situation, did the client stay on the streets, in ES or SH?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes (proceed below to 3: Chronic Questions) <input type="checkbox"/> No (the client is NOT Chronic, skip the rest of this page) 	<p>2C: LENGTH OF STAY: <i>How long was the client in a Housing Situation?</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> One Day or Less[Ⓕ] <input type="checkbox"/> Two Days to One Week[Ⓕ] <input type="checkbox"/> > One Week but < One Month <input type="checkbox"/> One to Three Months <input type="checkbox"/> > three months, but < 1 year <input type="checkbox"/> One Year or Longer <input type="checkbox"/> Client Does Not Know <input type="checkbox"/> Client Refused <p style="text-align: right; margin-right: 20px;">} 1 week or less</p> <p>[Ⓕ]<i>If the client reported <u>One Week or less</u> 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.</i></p> <p>On the night before the TH/PH Housing Situation, did the client stay on the streets, in ES or SH?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes (proceed below to 3: Chronic Questions) <input type="checkbox"/> No (the client is NOT Chronic, skip the rest of this page)

Head of Household Name: _____

3: CHRONIC QUESTIONS: (depending on your answer in the above questions).

3.1: Approximate Date <u>this current episode</u> 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. <ul style="list-style-type: none"> 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. 	<input type="checkbox"/> One Time <input type="checkbox"/> Two Times <input type="checkbox"/> Three Times <input type="checkbox"/> Four or more times <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> 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")

- | | | |
|---|---|--|
| <input type="checkbox"/> IL-514 DuPage | <input type="checkbox"/> IL-502 Waukegan/North Chicago/Lake | <input type="checkbox"/> IL-512 Bloomington/Central Illinois |
| <input type="checkbox"/> IL-511 SubCook | <input type="checkbox"/> IL-506 Joliet/Kendall/Grundy | <input type="checkbox"/> IL-518 Northwest/LaSalle |
| <input type="checkbox"/> IL-517 Aurora/Elgin/Kane | <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____ If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? Notes:	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____ If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? Notes:	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Alcohol and Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____ If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? Notes:	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Chronic Health Condition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know	____/____/____ If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Agency's LOGO

Head of Household Name: _____

<input type="checkbox"/> Client Refused	Notes:				
HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:				
Mental Health Problem <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:				
Developmental Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:				
Physical Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> 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								
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes:			\$			\$	
				\$			\$	
Unemployment Insurance								
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes:			\$			\$	
SSI: Supplemental Security Income								
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes:			\$			\$	
Social Security Disability Income								
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes:			\$			\$	
VA Service Connected								
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes:			\$			\$	
Private Disability Insurance								
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes:			\$			\$	

Agency's LOGO



Head of Household Name: _____

Worker's Compensation								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Temporary Assistance for Needy Families (TANF)								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
General Assistance								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Retirement Income from Social Security								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
VA Non-Service Connected								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Pension from a former job								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Child Support								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Alimony or Other Spousal Support								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Other Source (specify):								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	

TOTAL MONTHLY HOUSEHOLD INCOME
FY2019 AREA MEDIAN INCOME (AMI)

\$ _____

NUMBER OF HOUSEHOLD MEMBERS _____

Household Size

1 2 3 4 5 6 7 8

30% AMI	\$1,563	\$1,783	\$2,008	\$2,229	\$2,408	\$2,588	\$2,767	\$2,946
50% AMI	\$2,600	\$2,971	\$3,342	\$3,713	\$4,013	\$4,308	\$4,604	\$4,904
80% AMI	\$4,163	\$4,754	\$5,350	\$5,942	\$6,421	\$6,896	\$7,371	\$7,846
100% AMI	\$5,200	\$5,942	\$6,683	\$7,425	\$8,025	\$8,617	\$9,208	\$9,808

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)	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, Household Members: _____	
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, Household Members: _____	
TANF child care services	

Agency's LOGO



Head of Household Name: _____

<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
TANF transportation services	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Other TANF-Funded Services	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Other Source (specify):	
<input type="checkbox"/> Yes <input type="checkbox"/> 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	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Medicare	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Illinois All Kids (State Children's Health Insurance Program)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Veteran's Administration Medical Services	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Employer Provided Health Insurance	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Health Insurance obtained through COBRA	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Private Pay Health Insurance	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
State Health Insurance for Adults	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Indian Health Services Program	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Other	
<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Full Address Reported <input type="checkbox"/> Client Does Not Know		<input type="checkbox"/> Incomplete or estimated address reported <input type="checkbox"/> Client Refused		
Phone Number		Alternate Phone			
Email Address					
Start Date		End Date			
Client's Residence Notes					
Address Type	<input type="checkbox"/> After Program <input type="checkbox"/> Before Program-Last Permanent		<input type="checkbox"/> Before Program <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Agency's LOGO



Head of Household Name: _____

[Intentionally left blank]

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

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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		
	Notes:				
Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		
	Notes:				
Alcohol and Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		
	Notes:				
Chronic Health Condition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		
	Notes:				
HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		
	Notes:				
Mental Health Problem <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		
	Notes:				
Developmental Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		
	Notes:				
Physical Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		
	Notes:				

Agency's LOGO



Head of Household Name: _____

Universal Update Form

Head of Household

HMIS CLIENT ID#

UPDATE DATE

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FILL-IN AFTER SERVICEPOINT ENTRY

MONTH / DAY / YEAR

HOUSEHOLD INFORMATION

Relationship (to HoH)	SELF	Number in Household:	<i>Use a separate HH Member Supplemental page for each additional HH member</i>
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DOMESTIC VIOLENCE

		Client doesn't know	Client refused
Domestic Violence Victim/Survivor	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>
	(If Yes) how long ago was the last incident? <input type="checkbox"/> Within the past 3 months <input type="checkbox"/> 3-6 months ago <input type="checkbox"/> 6-12 months ago <input type="checkbox"/> More than a year ago <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		
	(If Yes) are you currently fleeing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Does Not Know <input type="checkbox"/> Client Refused		

LIVING SITUATION

Client Location

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

- | | | |
|---|---|--|
| <input type="checkbox"/> IL-514 DuPage | <input type="checkbox"/> IL-502 Waukegan/North Chicago/Lake | <input type="checkbox"/> IL-512 Bloomington/Central Illinois |
| <input type="checkbox"/> IL-511 SubCook | <input type="checkbox"/> IL-506 Joliet/Kendall/Grundy | <input type="checkbox"/> IL-518 Northwest/LaSalle |
| <input type="checkbox"/> IL-517 Aurora/Elgin/Kane | <input type="checkbox"/> IL-509 De Kalb | |

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

Current City _____ Current Zip _____

Head of Household Name: _____

DISABILITY

Does the client have a disabling condition? *If the disability response changes during program participation contact the HMIS Help Desk for steps on how to complete the update.*

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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Both Alcohol and Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Chronic Health Condition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Developmental Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Mental Health Problem <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Physical Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			

Head of Household Name: _____

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								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
				\$			\$	
Unemployment Insurance								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
SSI: Supplemental Security Income								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Social Security Disability Income								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
VA Service Connected								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Private Disability Insurance								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Worker's Compensation								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Temporary Assistance for Needy Families (TANF)								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
General Assistance								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Retirement Income from Social Security								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
VA Non-Service Connected Disability Pension								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Pension or retirement income from another job								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Child Support								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Alimony or Other Spousal Support								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Other Source (specify):								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	

Agency's LOGO



Head of Household Name: _____

**TOTAL MONTHLY HOUSEHOLD INCOME
FY2017 AREA MEDIAN INCOME (AMI)**

\$ _____

NUMBER OF HOUSEHOLD MEMBERS _____

Household Size	1	2	3	4	5	6	7	8
30% AMI	\$1,563	\$1,783	\$2,008	\$2,229	\$2,408	\$2,588	\$2,767	\$2,946
50% AMI	\$2,600	\$2,971	\$3,342	\$3,713	\$4,013	\$4,308	\$4,604	\$4,904
80% AMI	\$4,163	\$4,754	\$5,350	\$5,942	\$6,421	\$6,896	\$7,371	\$7,846
100% AMI	\$5,200	\$5,942	\$6,683	\$7,425	\$8,025	\$8,617	\$9,208	\$9,808

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)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
TANF child care services	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
TANF transportation services	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Other TANF-Funded Services	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Other Source (specify):	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:

Head of Household Name: _____

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	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Medicare	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Illinois All Kids (State Children's Health Insurance Program)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Veteran's Administration Medical Services	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Employer Provided Health Insurance	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Health Insurance obtained through COBRA	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Private Pay Health Insurance	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
State Health Insurance for Adults	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Indian Health Services Program	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Other	
<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Full Address Reported <input type="checkbox"/> Client Does Not Know		<input type="checkbox"/> Incomplete or estimated address reported <input type="checkbox"/> Client Refused		
Phone Number		Alternate Phone			
Email Address					
Start Date		End Date			
Client's Residence Notes					
Address Type	<input type="checkbox"/> After Program <input type="checkbox"/> Before Program-Last Permanent		<input type="checkbox"/> Before Program <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Agency's LOGO



Head of Household Name: _____

Universal Update Form

Household Member

HMIS CLIENT ID#

INTAKE/ENTRY DATE

--	--

FILL-IN AFTER SERVICEPOINT ENTRY

MONTH / DAY / YEAR

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

DISABILITY

Does the client have a disabling condition? *If the disability response changes during program participation contact the HMIS Help Desk for steps on how to complete the update.*

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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____ / ____ / ____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		
Notes:				
Both Alcohol and Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____ / ____ / ____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		
Notes:				
Chronic Health Condition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____ / ____ / ____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		
Notes:				
Developmental Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____ / ____ / ____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		
Notes:				

Agency's LOGO



Head of Household Name: _____

Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	_____ / _____ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	_____ / _____ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Mental Health Problem <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	_____ / _____ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Physical Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	_____ / _____ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			

Agency's LOGO



Head of Household Name: _____

Universal Exit Form

Head of Household

HMIS CLIENT ID#

EXIT DATE

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FILL-IN AFTER SERVICEPOINT ENTRY

MONTH / DAY / YEAR

REASON FOR LEAVING

- | | |
|--|--|
| <input type="checkbox"/> Completed Program | <input type="checkbox"/> Reached maximum time allowed |
| <input type="checkbox"/> Criminal activity / violence | <input type="checkbox"/> Unknown/Disappeared |
| <input type="checkbox"/> Death | <input type="checkbox"/> Moved from Service Area |
| <input type="checkbox"/> Disagreement with rules/persons | <input type="checkbox"/> No Client Contact |
| <input type="checkbox"/> End of Shelter Season (ES only) | <input type="checkbox"/> Voluntary Departure (IDHS) |
| <input type="checkbox"/> Left for housing opp. before completing program | <input type="checkbox"/> Unable to Identify Housing (RRH) |
| <input type="checkbox"/> Needs could not be met | <input type="checkbox"/> Permanent to Permanent transfer (including RRH) |
| <input type="checkbox"/> Non-compliance with program | <input type="checkbox"/> No longer meets population criteria |
| <input type="checkbox"/> Non-payment of rent | <input type="checkbox"/> Other: _____ |

DESTINATION

Homeless Situation	Temporary or Permanent Housing Situation	Other
<input type="checkbox"/> Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter <input type="checkbox"/> Safe Haven 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 abuse treatment facility or detox center	<input type="checkbox"/> Residential or halfway house with no homeless criteria <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Host home (non-crisis) <input type="checkbox"/> Staying or living with friends, temporary tenure (e.g., room, apartment or house) <input type="checkbox"/> Staying or living with family, temporary tenure (e.g., room, apartment or house) <input type="checkbox"/> Staying or living with family, permanent tenure <input type="checkbox"/> Staying or living with friends, permanent tenure <input type="checkbox"/> Moved from one HOPWA funded project to HOPWA PH <input type="checkbox"/> Moved from one HOPWA funded project to HOPWA TH <input type="checkbox"/> Rental by client with GPD TIP housing subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons <input type="checkbox"/> Rental by client, with RRH or equivalent subsidy <input type="checkbox"/> Rental by client, with Housing Choice Voucher (HCV) (tenant or project based) <input type="checkbox"/> Rental by client in a public housing unit <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy	<input type="checkbox"/> No exit interview completed <input type="checkbox"/> Deceased <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected <input type="checkbox"/> Other: _____

Head of Household Name: _____

DISABILITY

Does the client have a disabling condition? *If the disability response changes during program participation contact the HMIS Help Desk for steps on how to complete the update.*

- 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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Both Alcohol and Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Chronic Health Condition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Developmental Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Mental Health Problem <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Physical Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			

Head of Household Name: _____

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								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
				\$			\$	
Unemployment Insurance								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
SSI: Supplemental Security Income								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Social Security Disability Income								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
VA Service Connected								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Private Disability Insurance								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Worker's Compensation								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Temporary Assistance for Needy Families (TANF)								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
General Assistance								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Retirement Income from Social Security								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
VA Non-Service Connected Disability Pension								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Pension or retirement income from another job								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Child Support								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Alimony or Other Spousal Support								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Other Source (specify):								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	

Agency's LOGO



Head of Household Name: _____

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

FY2019 AREA MEDIAN INCOME (AMI)

Household Size	1	2	3	4	5	6	7	8
30% AMI	\$1,563	\$1,783	\$2,008	\$2,229	\$2,408	\$2,588	\$2,767	\$2,946
50% AMI	\$2,600	\$2,971	\$3,342	\$3,713	\$4,013	\$4,308	\$4,604	\$4,904
80% AMI	\$4,163	\$4,754	\$5,350	\$5,942	\$6,421	\$6,896	\$7,371	\$7,846
100% AMI	\$5,200	\$5,942	\$6,683	7,425	\$8,025	\$8,617	\$9,208	\$9,808

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)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members: _____
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members: _____
TANF child care services	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members: _____
TANF transportation services	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members: _____
Other TANF-Funded Services	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members: _____
Other Source (specify): _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members: _____

Agency's LOGO



Head of Household Name: _____

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	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Medicare	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Illinois All Kids (State Children's Health Insurance Program)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Veteran's Administration Medical Services	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Employer Provided Health Insurance	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Health Insurance obtained through COBRA	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Private Pay Health Insurance	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
State Health Insurance for Adults	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Indian Health Services Program	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Other	
<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Full Address Reported <input type="checkbox"/> Client Does Not Know		<input type="checkbox"/> Incomplete or estimated address reported <input type="checkbox"/> Client Refused		
Phone Number		Alternate Phone			
Email Address					
Start Date		End Date			
Client's Residence Notes					
Address Type	<input type="checkbox"/> After Program <input type="checkbox"/> Before Program-Last Permanent		<input type="checkbox"/> Before Program <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Head of Household Name: _____

Universal Exit Form

Household Member

HMIS CLIENT ID#

EXIT DATE

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FILL-IN AFTER SERVICEPOINT ENTRY

MONTH / DAY / YEAR

REASON FOR LEAVING

- | | |
|--|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Completed Program <input type="checkbox"/> Criminal activity / violence <input type="checkbox"/> Death <input type="checkbox"/> Disagreement with rules/persons <input type="checkbox"/> End of Shelter Season (ES only) <input type="checkbox"/> Left for housing opp. before completing program <input type="checkbox"/> Needs could not be met <input type="checkbox"/> Non-compliance with program <input type="checkbox"/> Non-payment of rent | <ul style="list-style-type: none"> <input type="checkbox"/> Reached maximum time allowed <input type="checkbox"/> Unknown/Disappeared <input type="checkbox"/> Moved from Service Area <input type="checkbox"/> No Client Contact <input type="checkbox"/> Voluntary Departure (IDHS) <input type="checkbox"/> Unable to Identify Housing (RRH) <input type="checkbox"/> Permanent to Permanent transfer (including RRH) <input type="checkbox"/> No longer meets population criteria <input type="checkbox"/> Other: _____ |
|--|--|

DESTINATION

Homeless Situation	Temporary or Permanent Housing Situation	Other
<ul style="list-style-type: none"> <input type="checkbox"/> Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter <input type="checkbox"/> Safe Haven <p>Institutional Situation</p> <ul style="list-style-type: none"> <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 	<ul style="list-style-type: none"> <input type="checkbox"/> Residential or halfway house with no homeless criteria <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Host home (non-crisis) <input type="checkbox"/> Staying or living with friends, temporary tenure (e.g., room, apartment or house) <input type="checkbox"/> Staying or living with family, temporary tenure (e.g., room, apartment or house) <input type="checkbox"/> Staying or living with family, permanent tenure <input type="checkbox"/> Staying or living with friends, permanent tenure <input type="checkbox"/> Moved from one HOPWA funded project to HOPWA PH <input type="checkbox"/> Moved from one HOPWA funded project to HOPWA TH <input type="checkbox"/> Rental by client with GPD TIP housing subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons <input type="checkbox"/> Rental by client, with RRH or equivalent subsidy <input type="checkbox"/> Rental by client, with Housing Choice Voucher (HCV) (tenant or project based) <input type="checkbox"/> Rental by client in a public housing unit <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy 	<ul style="list-style-type: none"> <input type="checkbox"/> No exit interview completed <input type="checkbox"/> Deceased <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected <input type="checkbox"/> Other: _____

Head of Household Name: _____

DISABILITY

Does the client have a disabling condition? *If the disability response changes during program participation contact the HMIS Help Desk for steps on how to complete the update.*

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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Both Alcohol and Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Chronic Health Condition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Developmental Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Mental Health Problem <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Physical Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			

Current Living Situation (Formerly known as Contacts)

Head of Household and Adults

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

1. CURRENT LIVING SITUATION

Homeless Situation	Institutional Situation	Transitional or Permanent Situation	Other
<ul style="list-style-type: none"> <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter <input type="checkbox"/> Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) <input type="checkbox"/> Safe Haven 	<ul style="list-style-type: none"> <input type="checkbox"/> Substance abuse treatment facility or detox center <input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Jail, prison or juvenile detention facility <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility 	<ul style="list-style-type: none"> <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client in a public housing unit <input type="checkbox"/> Rental by client, with GPD TIP housing subsidy <input type="checkbox"/> Rental by client, with Housing Choice Voucher (HCV) (tenant or project based) <input type="checkbox"/> Rental by client, with RRH or equivalent subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> Staying or living in a friend's room, apartment or house <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) 	<ul style="list-style-type: none"> <input type="checkbox"/> Other: _____ <input type="checkbox"/> Worker unable to confirm <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused

2. LOCATION DETAILS: LIST ADDITIONAL LOCATION INFORMATION TO IDENTIFY WHERE THE CONTACT TOOK PLACE

Current Living Situation (Formerly known as Contacts)

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ANSWER QUESTIONS (3-7) IF THE CLIENT IS IN AN INSTITUTIONAL, TEMPORARY OR PERMANENT LIVING SITUATION.

3. IS THE CLIENT GOING TO HAVE TO LEAVE THEIR CURRENT LIVING SITUATION WITHIN 14 DAYS?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused
4. HAS A SUBSEQUENT RESIDENCE BEEN IDENTIFIED?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused
5. DOES THE INDIVIDUAL OR FAMILY HAVE RESOURCES OR SUPPORT NETWORKS TO OBTAIN OTHER PERMANENT HOUSING?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused
6. HAS THE CLIENT HAD A LEASE OR OWNERSHIP INTEREST IN A PERMANENT HOUSING UNIT IN THE LAST 60 DAYS?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused
7. HAS THE CLIENT MOVED 2 OR MORE TIMES IN THE LAST 60 DAYS?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused