

Form designed for use by RHY-funded Basic Center Program shelter.

Staff: _____ Project Start Date: ____/____/____ Name of Head of Household: _____

Project Name (Enter Data As): _____

Client Record



Unless specifically required by a funder, clients may use a preferred name (rather than legal name) for HMIS purposes.

Name _____
First Middle Last Suffix

Name Data Quality ☐ Full Name Reported ☐ Partial, Street Name, or Code Name Reported



Best practice is to collect all nine digits of the SSN for all clients; CoC-, ESG-, and PATH-funded projects are only required to attempt to collect the last four digits of the SSN. Other projects must attempt to collect all nine digits of the SSN, though clients can refuse all or part of the SSN. Unless explicitly requested by the client, the first five digits of the SSN should not be deleted if previously recorded in HMIS.

Social Security Number _____ - _____ - _____

☐ Full SSN
Reported

☐ Approximate or Partial SSN
Reported

☐ Client doesn't
know

☐ Client prefers not to
answer

U.S. Veteran ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

Client Demographics

Date of Birth ____/____/____

☐ Full DOB Reported

☐ Approximate or Partial DOB
Reported

☐ Client doesn't
know

☐ Client prefers not to answer

Gender(s)
select all that apply

☐ Woman (Girl, if child)

☐ Transgender

☐ Different Identity (specify): _____

☐ Man (Boy, if child)

☐ Non-Binary

☐ Client doesn't
know

☐ Culturally Specific Identity (e.g. Two-Spirit)

☐ Questioning

☐ Client prefers not to answer

Race(s) and Ethnicity
select all that apply

☐ American Indian, Alaska Native, or Indigenous

☐ Black, African American, or African

☐ Middle Eastern or North African

☐ White

☐ Client prefers not to answer

☐ Asian or Asian American

☐ Hispanic/Latina/e/o

☐ Native Hawaiian or Pacific Islander

☐ Client doesn't know

Additional Race & Ethnicity

optional, specify

Relationship to Head of Household

☐ Self

☐ Head of household's child

☐ Head of household's spouse or partner

☐ Other: non-relation member

☐ Head of household's other relation member (other relation to head of household)

RHY Basic Center Program Status

Date of Status Determination ____/____/____

Youth Eligible for RHY Services

☐ No ☐ Yes

If no, reason why services are not funded by BCP grant

☐ Out of age range

☐ Ward of the State – Immediate Reunification

☐ Ward of the Criminal Justice System – Immediate Reunification

☐ Other

If yes, runaway youth

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

Enrollment CoC ☐ MO-500 St. Louis County ☐ MO-501 St. Louis City
☐ MO-600 Springfield/Greene, Christian, Webster Counties ☐ MO-602 Joplin/Jasper, Newton Counties
☐ MO-603 St. Joseph/Andrew, Buchanan, DeKalb Counties ☐ MO-606 Missouri Balance of State

Client location as of assessment/review date

i Select the county in which the client is residing (or sleeping at night if unhoused). This field does not need to match the CoC Code above.

Client Location (County) _____

Last Permanent Address

i Record the last zip code the client had for at least 90 days that was not in an emergency shelter, a transitional housing project, a safe haven, or a place not meant for habitation.

Zip Code of Last Permanent Address _____
☐ Full or Partial Zip Code Reported ☐ Client doesn't know ☐ Client prefers not to answer

Disabilities

Disabling Condition ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

Health Insurance

Covered by Health Insurance ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

Medicaid (MO HealthNet)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Medicare	<input type="checkbox"/> No	<input type="checkbox"/> Yes
State Children's Health Insurance Program	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Veteran's Health Administration	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Employer-Provided Health Insurance	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Health Insurance obtained through COBRA	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Private Pay Health Insurance	<input type="checkbox"/> No	<input type="checkbox"/> Yes
State Health Insurance for Adults	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Indian Health Services Program	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Other (specify): _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes

i HUD requires that the client be asked about each individual source of health insurance and requires an answer be recorded for each.

i **Data Entry Tip:**
Remember to end date old records and create new records each time a source of health insurance changes.

Disabilities

i If one or more of the options below with an asterisk(*) has been selected, the answer to "disabling condition" must be "yes."
If none of the answers below with an asterisk(*) has been selected, the answer to "disabling condition" may be "yes" or "no."

Disability type	Disability determination	If yes, expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?
Alcohol Use Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA
Both Alcohol and Drug Use Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA
Chronic Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA
Developmental Disability	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	(not applicable)
Drug Use Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA
HIV/AIDS	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	(not applicable)
Mental Health Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA
Physical Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA

DK = Client doesn't know; PNTA = Client prefers not to answer