ICA Missouri – SSVF Start – RRH [FY2024]   Child

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

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

ⓘ	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 Profile Additional Information [Optional]

Contact Information   _____

Emergency Contact   _____

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)   ☐ Man (Boy, if child)   ☐ Culturally Specific Identity (e.g. Two-Spirit)
☐ Transgender   ☐ Non-Binary   ☐ Questioning
☐ Different Identity (specify):   ☐ Client doesn't know   ☐ Client prefers not to answer
_____

Race(s) and Ethnicity
select all that apply
☐ American Indian, Alaska Native, or Indigenous   ☐ Asian or Asian American
☐ Black, African American, or African   ☐ Hispanic/Latina/e/o
☐ Middle Eastern or North African   ☐ Native Hawaiian or Pacific Islander
☐ White   ☐ Client doesn't know
☐ Client prefers not to answer

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)

Project CoC Code

ⓘ	If you're unsure which CoC code to select for your project, reach out to the helpdesk for assistance.

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

ⓘ 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

ⓘ 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

Housing Move-In Date

ⓘ Record the date of the first night the head of household spent living in the unit for permanent housing projects (incl. PSH, RRH, and OPH). This must be on or after the project start date. Leave blank if the client is not yet housed.

Housing Move-In Date _____/_____/_____

Health Insurance

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

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

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

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