

TVCOC VA Funded HMIS Enrollment Form (SSVF only)

	HOH-Household Member 1	Household Member 2	Household Member 3	Household Member 4				
PROJECT ENTRY DATE (e.g. 08/24/2017)								
SIGNED ROI DATE: (Release of Information/Client Consent)								
# in HouseHold (including self)								
First Name								
Middle Name								
Last Name								
DATE OF BIRTH (e.g.) 10/23/1978)								
SOCIAL SECURITY NUMBER								
GENDER	Male	Female	Male	Female	Male	Female	Male	Female
	Male to Female	Female to Male	Male to Female	Female to Male	Male to Female	Female to Male	Male to Female	Female to Male
	Gender Non-Conforming		Gender Non-Conforming		Gender Non-Conforming		Gender Non-Conforming	
VETERAN STATUS	Yes	No	Yes	No	Yes	No	Yes	No
RACE	<input type="checkbox"/> American Indian or Alaskan	<input type="checkbox"/> American Indian or Alaskan	<input type="checkbox"/> American Indian or Alaskan	<input type="checkbox"/> American Indian or Alaskan	<input type="checkbox"/> American Indian or Alaskan	<input type="checkbox"/> American Indian or Alaskan	<input type="checkbox"/> American Indian or Alaskan	<input type="checkbox"/> American Indian or Alaskan
	<input type="checkbox"/> Asian	<input type="checkbox"/> Asian	<input type="checkbox"/> Asian	<input type="checkbox"/> Asian	<input type="checkbox"/> Asian	<input type="checkbox"/> Asian	<input type="checkbox"/> Asian	<input type="checkbox"/> Asian
	<input type="checkbox"/> White	<input type="checkbox"/> White	<input type="checkbox"/> White	<input type="checkbox"/> White	<input type="checkbox"/> White	<input type="checkbox"/> White	<input type="checkbox"/> White	<input type="checkbox"/> White
	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Black or African American
	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Native Hawaiian or Pacific Islander
ETHNICITY: Are you Hispanic or Latino?	Yes	No	Yes	No	Yes	No	Yes	No
RELATIONSHIP TO HEAD OF HOUSEHOLD	Self	Partner/Spouse	Self	Partner/Spouse	Self	Partner/Spouse	Self	Partner/Spouse
	Child	Other Relation	Child	Other Relation	Child	Other Relation	Child	Other Relation
	Other:		Other:		Other:		Other:	
CURRENT ADDRESS (ALL PERSONS)	Street							
	City, State, Zip Code							
	County							
LAST PERMANENT ADDRESS	Street							
	City, State, Zip Code							
	County							
Move in / Move out dates	/ / / /	/ / / /	/ / / /	/ / / /	/ / / /	/ / / /	/ / / /	
MAILING ADDRESS (if different from current)	Street							
	City, State, Zip Code							
	County							
CONTACT INFO CLIENT	FMAIL							
	Cell Phone / Home Phone							

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HUD UNIVERSAL DATA for ALL PERSONS								
DISABLING CONDITION	Yes	No	Yes	No	Yes	No	Yes	No
Residence Prior to Program Entry - Residence Type: <i>(Where did you sleep last night)</i>	Emergency shelter or hotel/motel voucher	Hotel/motel paid for without assistance	Emergency shelter or hotel/motel voucher	Hotel/motel paid for without assistance	Emergency shelter or hotel/motel voucher	Hotel/motel paid for without assistance	Emergency shelter or hotel/motel voucher	Hotel/motel paid for without assistance
	Hospital or other residential non psychiatric	Foster care home/Foster care group home	Hospital or other residential non psychiatric	Foster care home/Foster care group home	Hospital or other residential non psychiatric	Foster care home/Foster care group home	Hospital or other residential non psychiatric	Foster care home/Foster care group home
	Place not meant for human habitation	Long-term care facility or nursing home	Place not meant for human habitation	Long-term care facility or nursing home	Place not meant for human habitation	Long-term care facility or nursing home	Place not meant for human habitation	Long-term care facility or nursing home
	Owned by client, w/ subsidy	Jail/prison/juvenile detention	Owned by client, w/ subsidy	Jail/prison/juvenile detention	Owned by client, w/ subsidy	Jail/prison/juvenile detention	Owned by client, w/ subsidy	Jail/prison/juvenile detention
	Owned by client WITH ongoing subsidy	Permanent housing for formerly homeless	Owned by client WITH ongoing subsidy	Permanent housing for formerly homeless	Owned by client WITH ongoing subsidy	Permanent housing for formerly homeless	Owned by client WITH ongoing subsidy	Permanent housing for formerly homeless
	Safe Haven / Relocation	Staying in family member's room	Safe Haven / Relocation	Staying in family member's room	Safe Haven / Relocation	Staying in family member's room	Safe Haven / Relocation	Staying in family member's room
	Psychiatric hospital/facility	Rental by client WITH ongoing subsidy	Psychiatric hospital/facility	Rental by client WITH ongoing subsidy	Psychiatric hospital/facility	Rental by client WITH ongoing subsidy	Psychiatric hospital/facility	Rental by client WITH ongoing subsidy
	Rental by client WITH VASH	Rental by client WITH GDP TIP Substance	Rental by client WITH VASH	Rental by client WITH GDP TIP Substance	Rental by client WITH VASH	Rental by client WITH GDP TIP Substance	Rental by client WITH VASH	Rental by client WITH GDP TIP Substance
	Staying or living at a friend's	abuse treatment or detox center	Staying or living at a friend's	abuse treatment or detox center	Staying or living at a friend's	abuse treatment or detox center	Staying or living at a friend's	abuse treatment or detox center
	Transitional housing for homeless	Other:	Transitional housing for homeless	Other:	Transitional housing for homeless	Other:	Transitional housing for homeless	Other:
Prior Living Situation - Length of Stay: <i>(How long have you been staying there?)</i>	1 day or less	week	1 day or less	week	1 day or less	week	1 day or less	week
	More than 1 week, less than 1 month	1 year or longer	More than 1 week, less than 1 month	1 year or longer	More than 1 week, less than 1 month	1 year or longer	More than 1 week, less than 1 month	1 year or longer
Approximate Date Homelessness Started:	/ /		/ /		/ /		/ /	
Number of occasions the client has been on the streets or emergency shelter in the past 3 years	_____ times in the past 3 years		_____ times in the past 3 years		_____ times in the past 3 years		_____ times in the past 3 years	
	(occasions must be separated by at least 7 nights)							

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Number of TOTAL months homeless on the street or in emergency shelter in the past 3 years	_____ months in the past 3 years		_____ months in the past 3 years		_____ months in the past 3 years		_____ months in the past 3 years	
VETERAN ASSESSMENT for ALL ADULTS								
DD214 Receive Date (not required)	/ / / /		/ / / /		/ / / /		/ / / /	
Service Connected Disability (not required)								
Branch Military	Army	Navy	Army	Navy	Army	Navy	Army	Navy
	Airforce	Marines	Airforce	Marines	Airforce	Marines	Airforce	Marines
	Coast Guard	National Guard	Coast Guard	National Guard	Coast Guard	National Guard	Coast Guard	National Guard
Discharge Status	Honorable	Dishonorable	Honorable	Dishonorable	Honorable	Dishonorable	Honorable	Dishonorable
	Other:		Other:		Other:		Other:	
Date(s) Entered Service	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Date(s) Separated from Service	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Military Operations / Theatre Served:	World War II	Korean War	World War II	Korean War	World War II	Korean War	World War II	Korean War
	Vietnam War	PersianGulf War	Vietnam War	PersianGulf War	Vietnam War	PersianGulf War	Vietnam War	PersianGulf War
	Iraqi Freedom	Iraq New Dawn	Iraqi Freedom	Iraq New Dawn	Iraqi Freedom	Iraq New Dawn	Iraqi Freedom	Iraq New Dawn
	Other Peace-keeping Operations		Other Peace-keeping Operations		Other Peace-keeping Operations		Other Peace-keeping Operations	
PROGRAM DATA ASSESSMENT for ALL ADULTS								
Non Cash Benefits?	Yes	No	Yes	No	Yes	No	Yes	No
Non Cash Benefits List:	WIC	SNAP	WIC	SNAP	WIC	SNAP	WIC	SNAP
	Section 8	TANF	Section 8	TANF	Section 8	TANF	Section 8	TANF
	Other:		Other:		Other:		Other:	
HEALTH INSURANCE	Yes	No	Yes	No	Yes	No	Yes	No
LAST GRADE COMPLETED (EDUCATION)								
SSVF DATA for ALL VETERANS								
Percent of AMI	Less than 30%	30%	Less than 30%	30%	Less than 30%	30%	Less than 30%	30%
	31-50%	51% - 100%	31-50%	51% - 100%	31-50%	51% - 100%	31-50%	51% - 100%
VA Medical Center (VAMC) Station Number (up to 8 characters) - <i>List found here:</i> https://tvchomeless.org/hmis/downloads/								
	* VA Medical Center Station Number must be recorded, even if the individual does not receive VA benefits. This is to locate the nearest VAMC station center to the individual, if they need those benefits.							
Number of visits to emergency room in the past year.								
Approx. number of nights in jail/prison in past year.								

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DISABLING CONDITIONS for all persons								
SUBSTANCE ABUSE PROBLEM	No	Alcohol Abuse	No	Alcohol Abuse	No	Alcohol Abuse	No	Alcohol Abuse
	Substance Abuse	Both Alcohol & Substance	Substance Abuse	Both Alcohol & Substance	Substance Abuse	Both Alcohol & Substance	Substance Abuse	Both Alcohol & Substance
Expected to substantially impair ability to live independently:	Yes	No	Yes	No	Yes	No	Yes	No
Currently receiving services/treatment for this condition:	Yes	No	Yes	No	Yes	No	Yes	No
MENTAL HEALTH CONDITION	Yes	No	Yes	No	Yes	No	Yes	No
Expected to substantially impair ability to live independently:	Yes	No	Yes	No	Yes	No	Yes	No
Currently receiving services/treatment for this condition:	Yes	No	Yes	No	Yes	No	Yes	No
DEVELOPMENTAL DISABILITY	Yes	No	Yes	No	Yes	No	Yes	No
Expected to substantially impair ability to live independently:	Yes	No	Yes	No	Yes	No	Yes	No
Currently receiving services/treatment for this condition:	Yes	No	Yes	No	Yes	No	Yes	No
CHRONIC HEALTH CONDITION	Yes	No	Yes	No	Yes	No	Yes	No
Expected to substantially impair ability to live independently:	Yes	No	Yes	No	Yes	No	Yes	No
Currently receiving services/treatment for this condition:	Yes	No	Yes	No	Yes	No	Yes	No
HIV/AIDS	Yes	No	Yes	No	Yes	No	Yes	No
Expected to substantially impair ability to live independently:	Yes	No	Yes	No	Yes	No	Yes	No
Currently receiving services/treatment for this condition:	Yes	No	Yes	No	Yes	No	Yes	No
PHYSICAL DISABILITY	Yes	No	Yes	No	Yes	No	Yes	No
Expected to substantially impair ability to live independently:	Yes	No	Yes	No	Yes	No	Yes	No
Currently receiving services/treatment for this condition:	Yes	No	Yes	No	Yes	No	Yes	No
HEALTH INSURANCE ASSESSMENT for ALL ADULTS								
HEALTH INSURANCE	Yes	No	Yes	No	Yes	No	Yes	No
	Medicaid	Medicare	Medicaid	Medicare	Medicaid	Medicare	Medicaid	Medicare
	State Childrens	State Adult	State Childrens	State Adult	State Childrens	State Adult	State Childrens	State Adult
	Veterans	Employer Provided	Veterans	Employer Provided	Veterans	Employer Provided	Veterans	Employer Provided
	Private Pay	COBRA	Private Pay	COBRA	Private Pay	COBRA	Private Pay	COBRA
	Other:		Other:		Other:		Other:	

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FINANCIAL ASSESSMENT for ALL ADULTS								
AMI COUNTY SERVED								
Income from any source	Yes	No	Yes	No	Yes	No	Yes	No
Earned Income (Employment Income)								
Unemployment Insurance								
Supplimental Security Income (SSI)								
Social Security Disability Income (SSDI)								
VA Service-Connected Disability Compensation								
Private Disability Insurance								
TANF								
General Public Assistance								
Retirement Income from SS								
VA Non-Service Disabiliy								
Pension or retirement income from a former job								
Child support								
Alimony or other spousal support								
Other income								
Workers Compensation								
TOTAL INCOME:								

I understand that the information provided will be verified to the fullest extent possible and that I may be subject to prosecution for providing false or fraudulent information. I certify that the above information provided is true and correct to the best of my knowledge and belief. My signature below is my agreement and commitment to the above listed housing plan. I recognize that with my consent, my Case Manager may revise the housing plan over time.

CLIENT SIGNATURE _____ DATE _____

CASE MANAGER SIGNATURE _____ DATE _____