**NEBRASKA PATH INTAKE**

|  |
| --- |
| **DATE OF DATA COLLECTION** |
|   |  | **/** |  |  | **/** |  |  |  |  |

|  |
| --- |
| **HMIS CLIENT ID - For HMIS Users only** |
|  |  |  |  |  |  |  |  |  |

Month Day Year

|  |
| --- |
| **Name Data Quality** |
|  | Full name reported |
|  | Partial, street name or code name reported |
|  | Client doesn’t know |
|  | Client prefers not to answer |
|  | Data Not Collected  |

|  |
| --- |
| **NAME** |
| Last Name |  |
| First Name |  |
| Middle Name |  |
| Suffix (Jr, III) |  |
| Alias/Maiden |  |

|  |  |
| --- | --- |
| **SOCIAL SECURITY NUMBER** | **SSN Data Quality** |
|  |  | Full Reported |  | Approximate or Partial Reported |  | Client doesn’t know |  | Client prefers not to answer |  | Data not collected |

|  |  |
| --- | --- |
| **DATE OF BIRTH (mm/dd/yyyy)** | **DOB Data Quality** |
|  |  | Full Reported |  | Approximate or Partial Reported |  | Client doesn’t know |  | Client prefers not to answer |  | Data not collected |

|  |
| --- |
| **PRONOUNS (optional)** |
|  | She/Her/Hers |  | He/Him/His |  | They/Them/Theirs |  | Client doesn’t know |  | Client prefers not to answer |  | Data not collected |
|  **Manual Entry:**  |

|  |
| --- |
| **SEX** |
|  | Female |  | Client doesn’t know |
|  | Male |  | Client prefers not to answer |
|  |  |  | Data not collected |

|  |
| --- |
| **RACE & ETHNICITY (as many as are applicable)** |
|  | American Indian, Alaska Native, or Indigenous |  | Native Hawaiian or Pacific Islander |
|  | Asian or Asian American |  | White |
|  | Black, African American, or African |  | Client doesn’t know |
|  | Hispanic/Latina/o |  | Client prefers not to answer |
|  | Middle Eastern or North African |  | Data not collected |
|  | Additional Race and Ethnicity Detail:  |

|  |
| --- |
| **VETERAN STATUS** |
|  | Yes |  | No |  | Client doesn’t know |  | Client prefers not to answer |  | Data not collected |

|  |  |
| --- | --- |
| **ZIP CODE OF LAST PERMANENT ADDRESS:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **PHONE NUMBER:** |  | **EMAIL ADDRESS:** |  |

|  |
| --- |
| **RELATIONSHIP TO HEAD OF HOUSEHOLD** |
|  | Self (head of household) |  | Head of Household’s other relation member(other relation to Head of Household) |
|  | Head of Household’s child |
|  | Head of Household’s spouse or partner |  | Other: non-relation member |

|  |
| --- |
| **CONNECTION WITH SOAR** |
|  | Yes |  | No |  | Client doesn’t know |  | Client prefers not to answer |  | Data not collected |

|  |
| --- |
| **HOUSING STATUS** |
|  | Category 1 - Homeless |  | At-risk of homelessness |
|  | Category 2 – At imminent risk of losing housing |  | Stably housed |
|  | Category 3 – Homeless only under other federal statutes |  | Client doesn’t know |
|  | Category 4 – Fleeing domestic violence |  | Client prefers not to answer |
|  |  |  | Data not collected |

|  |
| --- |
| **PRIOR LIVING SITUATION: TYPE OF RESIDENCE – Where did the client live immediately prior to this project entry? Select one type of residence, follow the arrows and bold instructions to complete other sections.** |
|  | Client doesn’t know |  | Client prefers not to answer |  | Data not collected |
| **Homeless** | **Institutional** | **Temporary & Permanent Housing** |
|  | Place not meant for habitation (e.g., a vehicle, abandoned building, bus/train station, airport or anywhere outside) |  | Foster care home or foster care group home |  | Transitional housing for homeless persons (including homeless youth) |
|  | Emergency shelter, including hotel or motel paid for withemergency shelter voucher, Host Home shelter |  | Hospital or other residential non- psychiatric medical facility |  | Residential or halfway house with no homeless criteria  |
|  | Safe Haven |  | Jail, prison, or juvenile detention facility |  | Hotel or motel paid for without emergency shelter voucher |
|  |  |  | Long-term care facility or nursing home |  | Host Home (non-crisis) |
|  |  |  | Psychiatric hospital or other psychiatric facility |  | Staying or living in a friend’s room, apartment, or house |
|  |  |  | Substance abuse treatment facility or detox center |  | Staying or living in a family member’s room, apartment, or house |
|   |   |  |  |  | Rental by client, no ongoing subsidy |
|   |   |  |  |  | Rental by client with ongoing housing subsidy: |
|   |   |  |  |  GDP TIP housing subsidy VASH housing subsidy RRH or equivalent subsidy HCV voucher (tenant or project based) (not dedicated) Public housing unit Rental by client, with other ongoing housing subsidy Housing Stability Voucher Family Unification Program Voucher (FUP) Foster Youth to Independence Initiative (FYI) Permanent Supportive Housing Other permanent housing dedicated for formerly homeless persons |
|   |   |   |  | Owned by client, with ongoing subsidy |
|  |  |  |  | Owned by client, no ongoing subsidy |
|   |   |   |  |

|  |
| --- |
| **PRIOR LIVING SITUATION: LENGTH OF STAY – How long did the client stay in that place?****For responses in the shaded boxes, follow the arrows to complete PRIOR LIVING SITUATION: BREAK IN HOMELESSNESS.** |
|  | 1 night or less |  | 1 night or less |  | 1 night or less |
|  | 2 to 6 nights |  | 2 to 6 nights |  | 2 to 6 nights |
|  | 1 week or more, but less than 1 month |  | 1 week or more, but less than 1 month |  | 1 week or more, but less than 1 month |
|  | 1 month or more, but less than 90 days |  | 1 month or more, but less than 90 days |  | 1 month or more, but less than 90 days |
|  | 90 days or more, but less than 1 year |  | 90 days or more, but less than 1 year |  | 90 days or more, but less than 1 year |
|  | 1 year or longer |  | 1 year or longer |  | 1 year or longer |
|  | Client doesn’t know |  | Client doesn’t know |  | Client doesn’t know |
|  | Client prefers not to answer |  | Client prefers not to answer |  | Client prefers not to answer |
|  | Data not collected |  | Data not collected |  | Data not collected |
|  |  |  |

|  |
| --- |
| **PRIOR LIVING SITUATION: BREAK IN HOMELESSNESS****On the night before entering the Prior Living Situation, did the client stay on the streets or in emergency shelter?** |
| **Complete Frequency & Length** **of Homelessness Below** |  | **Yes [Complete Frequency & Length]** |  | **Yes [Complete Frequency & Length]** |
|  | No |  | No |
|  | Client doesn’t know |  | Client doesn’t know |
|  | Client prefers not to answer |  | Client prefers not to answer |
|  | Data not collected |  | Data not collected |

|  |
| --- |
| **PRIOR LIVING SITUATION: FREQUENCY & LENGTH OF HOMELESSNESS** |
| **Approximate date this episode of homelessness started: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Regardless of where they stayed last night, number of times the client has been on the streets or in emergency shelter in the past 3 years including today** |
|  | One time |  | Client doesn’t |
|  | Two times |  | Client prefers not to answer |
|  | Three times |  | Data not collected |
|  | Four or more times |  |  |
| **Total number of months homeless on the street or in emergency shelter in the past 3 years** |
|  | One month (this time is the first month) |  | Client doesn’t |
|  | Between 2 and 12 Months **→** **Enter total number of months:** \_\_\_\_\_\_\_\_ |  | Client prefers not to answer |
|  | More than 12 months |  | Data not collected |

|  |  |
| --- | --- |
| **COUNTY OF LAST PERMANENT ADDRESS:** |  |

|  |  |
| --- | --- |
| **DATE OF ENGAGEMENT (mm/dd/yyyy)** | **DATE OF PATH STATUS DETERMINATION (mm/dd/yyyy)** |
|  |  |

|  |
| --- |
| **CLIENT BECAME IN ENROLLED IN PATH** |
|  | Yes |  | No |
| **If NO, reason not enrolled** |
|  | Client was found ineligible for PATH |  | Unable to locate client |
|  | Client was not enrolled for other reason(s) |  |  |

|  |
| --- |
| **DISABLING CONDITION** |
|  | Yes |  | No |  | Client doesn’t know |  | Client prefers not to answer |  | Data not collected |
| **Answer ‘Yes’ or ‘No’ for each disability type.** If the client selects ‘Yes’ for Physical, Chronic, Mental Health or any of the three Substance Use Disorders, you must also complete the shaded sections below. |
| **Disability Type** | **Yes** | **No** | **CDK** | **CPNA** | **DNC** | **If Yes: Expected to be of long-continued and** **indefinite duration and substantially impairs** **client’s ability to live independently?** |
| Physical Disability |  |  |  |  |  |  Yes |  No |  CDK |  CPNA |  DNC |
| Developmental Disability  |  |  |  |  |  |  |  |  |  |  |
| Chronic Health Condition  |  |  |  |  |  |  Yes |  No |  CDK |  CPNA |  DNC |
| HIV/AIDS |  |  |  |  |  |  |  |  |  |  |
| Mental Health Disorder |  |  |  |  |  |  Yes |  No |  CDK |  CPNA |  DNC |
| Substance Use Disorder |  |  |  |  |  |  |  |  |  |  |
| **If yes for Substance Use Disorder, please indicate:** |  Alcohol use disorder, |  Yes |  No |  CDK |  CPNA |  DNC |
|  Drug use disorder, OR |  Yes |  No |  CDK |  CPNA |  DNC |
|  Both alcohol and drug use disorders |  Yes |  No |  CDK |  CPNA |  DNC |

|  |
| --- |
| **SURVIVOR OF DOMESTIC VIOLENCE** |
|  | Yes |  | No |  | Client doesn’t know |  | Client prefers not to answer |  | Data not collected |



|  |
| --- |
| **If YES, when experience occurred** |
|  | Within the past three months |  | Client doesn’t know |
|  | Three to six months ago (excluding six months exactly) |  | Client prefers not to answer |
|  | Six months to one year ago (excluding one year exactly) |  | Data not collected |
|  | One year ago, or more |   |



|  |
| --- |
| **If YES, are you currently fleeing?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client prefers not to answer |  | Data not collected |

|  |
| --- |
| **INCOME FROM ANY SOURCE – Do the head of household or any adults currently have any income from any source?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client prefers not to answer |  | Data not collected |
| **If “YES” for Income from any Source, indicate all sources and dollar amounts for the source that apply**  |
| **Source of Income** | **Yes** | **No** | **Monthly Amount**  |
| Earned Income (i.e., employment income)  |  |  | $ |
| Unemployment Insurance  |  |  | $ |
| Supplemental Security Income (SSI)  |  |  | $ |
| Social Security Disability Insurance (SSDI)  |  |  | $ |
| VA Service-Connected Disability Compensation  |  |  | $ |
| VA Non-Service-Connected Disability Pension  |  |  | $ |
| Private Disability Insurance |  |  | $ |
| Worker’s Compensation  |  |  | $ |
| Temporary Assistance for Needy Families (TANF) |  |  | $ |
| General Assistance (GA)  |  |  | $ |
| Retirement income from Social Security |  |  | $ |
| Pension or retirement income from a former job  |  |  | $ |
| Child support |  |  | $ |
| Alimony and other spousal support  |  |  | $ |
| Other income source (specify): |  |  | $ |
| **Total monthly income from all sources** | $ |

|  |
| --- |
| **NON-CASH BENEFITS - Do the head of household or any adults receive non-cash benefits from any source?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client prefers not to answer |  | Data not collected |
| **If “YES” for Non-Cash Benefits, indicate all sources that apply**  |
|  | Supplemental Nutrition Assistance Program (SNAP)(Previously known as Food Stamps) |  | TANF Child Care Services  |
|  | TANF Transportation Services  |
|  | Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) |  | Other TANF-funded Services  |
|  | Other Non-Cash Benefit (specify): |

|  |
| --- |
| **COVERED BY HEALTH INSURANCE** |
|  | Yes |  | No |  | Client doesn’t know |  | Client prefers not to answer |  | Data not collected |
| **If YES for Covered by Health Insurance, indicate all sources that apply** |
|  | **MEDICAID \*** |  | Health Insurance obtained through COBRA  |
|  | MEDICARE |  | Private Pay Health Insurance  |
|  | State Children’s Health Insurance Program (SCHIP) |  | State Health Insurance for Adults |
|  | Veteran’s Health Administration (VHA) |  | Indian Health Services Program |
|  | Employer-Provided Health Insurance  |  | Other (specify): |
| **\* If you do not have Medicaid, have you applied for Medicaid?** |  | Yes |  | No |
| **\* If you have Medicaid or have applied for Medicaid,** may we share your contact information with the Department of Health & Human Services Medicaid and Long-term Care Division so you can receive information about Medicaid from a managed care organization? |  | Yes |  | No |

|  |
| --- |
| **HIGHEST LEVEL OF SCHOOL COMPLETED** |
|  | No schooling completed |  | 10th grade |  | Post-secondary school |
|  | Nursery school to 4th grade |  | 11th grade |  | Client doesn’t know |
|  | 5th grade or 6th grade |  | 12th grade, no diploma |  | Client prefers not to answer |
|  | 7th grade or 8th grade |  | High school diploma |  | Data not collected |
|  | 9th grade |  | GED |  |  |

|  |
| --- |
| **CURRENT LIVING SITUATION** |
| **Homeless** |  | Place not meant for habitation (e.g., a vehicle, abandoned building, bus/train station, airport or anywhere outside) |
|  | Emergency shelter, including hotel or motel paid for with emergency shelter voucher, Host Home shelter |
|  | Safe Have |
| **Institutional** |  | Foster care home or foster care group home |
|  | Hospital or other residential non-psychiatric medical facility |
|  | Jail, prison, or juvenile detention facility |
|  | Long-term care facility or nursing home |
|  | Psychiatric hospital or other psychiatric facility |
|  | Substance abuse treatment facility or detox center |
| **Temporary Housing** |  | Transitional housing for homeless persons (including homeless youth)  |
|  | Residential project or halfway house with no homeless criteria  |
|  | Hotel or motel paid for without emergency shelter voucher |
|  | Host Home (non-crisis) |
|  | Staying or living in a friend’s room, apartment, or house |
|  | Staying or living in a family member’s room, apartment, or house |
| **Permanent Housing** |  | Rental by client, no ongoing housing subsidy |
|  | Rental by client, with ongoing housing subsidy: |
|  |  GPD TIP housing subsidy |
|  |  VASH housing subsidy |
|  |  RRH or equivalent subsidy |
|  |  HCV voucher (tenant or project based) (not dedicated) |
|  |  Public housing unit |
|  |  Rental by client with other ongoing housing subsidy |
|  |  Housing Stability Voucher |
|  |  Family Unification Program Voucher (FUP) |
|  |  Foster Youth to Independence Initiative (FYI) |
|  |  Permanent Supportive Housing |
|  |  Other permanent housing dedicated for formerly homeless persons |
|  | Owned by client with ongoing housing subsidy |
|  | Owned by client, no ongoing housing subsidy |
| **Other** |  | Other (specify): |
|  | Worker unable to determine |
|  | Client doesn’t know |
|  | Client prefers not to answer |
|  | Data not collected |
| **Living Situation Verified By:** |
|  | NE-500 Balance of State |  | NE-501 Omaha/MACCH |  | NE-502 Lincoln |
| **Is client going to have to leave their current living situation within 14 days?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client prefers not to answer |  | Data not collected |
| **Has a subsequent residence been identified?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client prefers not to answer |  | Data not collected |
| **Does individual or family have resources or support networks to obtain other permanent housing?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client prefers not to answer |  | Data not collected |
| **Has the client had a lease or ownership interest in a permanent housing unit in the last 60 days?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client prefers not to answer |  | Data not collected |
| **Has the client moved 2 or more times in the last 60 days?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client prefers not to answer |  | Data not collected |



**Nebraska Management Information System**

**Client Release of Information**

The Nebraska Management Information System (NMIS) manages a database of homeless services information in order to improve coordination of services that support people who are homeless or at risk of homelessness and to better understand homelessness, improve service delivery, and evaluate the effectiveness of services provided. Participation in data collection is a critical component of our community’s ability to provide the most effective services and housing possible. The information that is collected is protected by limiting access to the database and limiting what information may be shared.

**The information to be collected and shared may include:**

* name, date of birth, sex, race and ethnicity, social security number, contact information, location, prior residence
* disabling condition, veteran status, domestic violence, photo (if applicable)
* family composition, income, non-cash benefits, homeless history, housing information, health insurance
* program entry and exit, assessments, services provided

**By signing this form, I authorize the Participating Agencies and their representatives to share basic information regarding me and my family members listed below.**

**I understand that:**

* My information will be shared for the purpose of assessing my needs for housing, utility assistance, food, counseling, and/or other services.
* Every person and every agency that is authorized to read or enter information into the system has signed an agreement to maintain the security and confidentiality of the information. I have the right to view the client confidentiality policies used by the NMIS Participating Agencies and to see a list of Participating Agencies before signing this form.
* NMIS data access and sharing comply with federal, state, and local regulations protecting the confidentiality of client records. My information cannot be disclosed without my written consent unless otherwise provided for in the regulations.
* Auditors or funders who have legal rights to review the work of this agency, including the U.S. Department of Housing and Urban Development and the Nebraska Department of Health and Human Services Homeless Assistance Program may see my complete file if services received are funded by their organization.
* Signing this Release of Information does not guarantee that I will receive assistance.
* Refusal to authorize sharing of my information does not disqualify me from receiving assistance.
* This release is valid for one year from the date of my signature below, unless noted otherwise\*.
* I may withdraw my consent at any time. This authorization will remain in effect until I revoke it in writing. If I revoke my authorization, all information about me already in the database will remain.

**CLIENT RELEASE OF INFORMATION**

**\_\_\_\_ Yes, I agree to share my NMIS information.** \*Expiration Date(if other than 1 year) \_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_ No, I do not agree to share my NMIS information. Only our agency will see your program participation information.**

Client Printed Name Client Signature Date

Signature of Guardian or Authorized Representative (when required) Relationship to Client Date

Agency Staff Printed Name Date

**This Release of Information also applies to the following dependent children in the household who are 18 years of age or younger:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| First Name | Last Name | Birthdate |  | First Name | Last Name | Birthdate |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |