Missouri Department of Mental Health

Shelter Plus Care Program

Part 2: Participant HMIS Information

What is an HMIS?

"HMIS" means *homeless management information system*, an online database of homeless services required by HUD for its homeless assistance program grantees. HUD and homeless service providers, including the Missouri Department of Mental Health, use HMIS data to better coordinate available resources to serve individuals and families experiencing homelessness. The information collected on this form will be entered into the HMIS system in use in the area where the new Shelter Plus Care Participant will live.

Why "Part 2"?

This form is the second part of the information gathering process DMH Housing is required by HUD to conduct in order to serve disabled individuals and families experiencing homelessness through the Shelter Plus Care program. "Part 1" is the application process. DMH Housing used to collect this information in the Application for Shelter Plus Care. To streamline and shorten the application process, we now collect this information at the time when an eligible person or household is actually about to enter the program.

How Do I Use This Form?

1. When a person or household can be approved for Shelter Plus Care assistance, DMH Housing contacts the case manager and informs him or her that assistance is available, and that a Participant HMIS Form must be prepared.
2. To get a copy of this form, visit http://dmh.mo.gov/housing/housingunit/shelterpluscare.html#applyingforspcassistance and download the form; or contact DMH Housing at 573-751-9206 or housing@dmh.mo.gov to have the form emailed to you.
3. Fill out the form completely. The person entering the Shelter Plus Care program and his or her Case Manager should do this together.
4. Sections 2 and 3 do not need to be completed if there are no other adults or minors in the Participant's household.
5. The *Notice of Client Rights* form does not need to be completed if the Participant resides in Jackson County, St. Louis County, St. Louis City, or the St. Joseph area (Andrew, Buchanan, and DeKalb Counties).
6. When you have completed the form:
    a. If you live in Jackson County, St. Louis County, St. Louis City, or the St. Joseph area (Andrew, Buchanan, and DeKalb Counties), take the form with you to the local processing center agency when you go for your initial intake meeting. The processing center agency contacts the case manager to set a date for the intake meeting after DMH Housing has made the Shelter Plus Care referral. The intake meeting will not proceed if you don't have a completed Participant HMIS Information form with you.
    b. If you live in any other part of Missouri, fax the completed form to DMH Housing at **573-526-7797**. You can also scan the completed form and email it as a PDF file to housing@dmh.mo.gov, but the email must be encrypted. Do not email the form unless your agency has an encryption process for outgoing email; emailing the form without encryption is a violation of the confidentiality provisions of HIPAA. After DMH Housing receives the form, it will make the referral to a processing center agency. You do not need to take the form with you when you attend your intake meeting at the processing center agency.

Questions? Call 573-751-9206 or email housing@dmh.mo.gov.

Shelter Plus Care Participant HMIS Form

➢SECTION 1. PARTICIPANT'S INFORMATION

Participant Name: _____

Social Security Number: _____ - _____ - _____

Date of Birth: _____ / _____ / _____

☐ **U.S citizen** ☐ **Eligible non-citizen**

Race (check all that apply):
☐ American Indian/Alaska Native
☐ Asian
☐ Black/African-American
☐ Native Hawaiian/Other Pacific Islander
☐ White

Ethnicity:
☐ Hispanic
☐ non-Hispanic

Gender:
☐ female ☐ male
☐ transgender, male to female
☐ transgender, female to male

Marital Status:
☐ single ☐ married ☐ unmarried couple
☐ separated ☐ widowed ☐ divorced

What is your general physical health status?
☐ excellent ☐ very good ☐ good ☐ fair ☐ poor

Are you pregnant? ☐ Yes ☐ No No. of months: _____

Delivery date: _____ / _____ / _____

.....

Last Permanent Address/Location:
What is the zip code of your last permanent address (a household paying rent or a mortgage where you last lived for at least 90 days)?

Zip Code _____

Where did you spend the night before you filled out the Application for Shelter Plus Care?

[*The answer below must match the answer given on Attachment C, Verification of Homelessness, in your Shelter Plus Care Program Application, Part 1.*]

☐ emergency shelter (includes a domestic violence shelter and a motel or hotel room paid for by an emergency shelter voucher)
☐ a place not meant for human habitation (car, park, etc.)
☐ transitional housing for homeless persons
☐ Safe Haven
☐ jail or prison
☐ substance abuse treatment facility or detox center
☐ hospital or other residential non-psychiatric medical facility
☐ psychiatric hospital or similar facility
☐ long-term care facility or nursing home

How long did you stay in the above situation?
☐ one day or less ☐ two days to one week
☐ more than one week but less than one month
☐ one to three months
☐ more than three months but less than one year
☐ one year or longer

Do you have health insurance? Check all that apply.
☐ Medicare ☐ Medicaid (aka MO HealthNet)
☐ employer-provided health insurance
☐ health insurance obtained through COBRA
☐ VA Medical Services ☐ private pay insurance
☐ no insurance

If you have no health insurance, please state the reason why:
☐ applied; decision pending ☐ applied; not eligible
☐ have not applied

.....

Are you currently in school and/or working on any degree or certificate? ☐ Yes ☐ No

Have you received vocational training or received any apprenticeship certificates? ☐ Yes ☐ No

What is the highest grade you've completed?
☐ no school completed ☐ nursery school to 4th grade
☐ 5th grade to 6th grade ☐ 7th grade to 8th grade
☐ 9th grade ☐ 10th grade
☐ 11th grade ☐ 12th grade, no diploma
☐ high school diploma ☐ GED
☐ post-secondary education

Are you employed? ☐ Yes ☐ No

If yes, what type of employment is it?
☐ permanent ☐ temporary ☐ seasonal

How many hours did you work last week? _____

If not employed, are you looking for work?
☐ Yes ☐ No

Have you ever been a victim of domestic violence?
☐ Yes ☐ No ☐ don't know ☐ refused to answer

If yes, how long in the past did this occur?
☐ Within past three months
☐ 3-6 months ago (excluding six months exactly)
☐ 6-12 months ago (excluding one year exactly)
☐ One year ago or more
☐ refused to answer

Are you currently fleeing domestic violence?
☐ Yes ☐ No ☐ don't know ☐ refused to answer

Do you have a mental illness?
☐ Yes ☐ No

If yes, is the mental illness a disabling condition?
(*See definition of "disabling condition" at the end of this page.)
☐ Yes ☐ No
[*If you stated that your disability is a mental illness or a dual diagnosis that includes mental illness on the Shelter Plus Care Program Application Part 1, then you must answer "yes" to the above question.*]
Are you receiving services or treatment for the mental illness? ☐ Yes ☐ No

Do you have a substance use disorder?
☐ yes, alcohol use ☐ yes, drug use
☐ yes, both alcohol and drug use ☐ No

If yes, is the substance use disorder a disabling condition? ☐ Yes ☐ No
[*If you stated that your disability is a substance use disorder or a dual diagnosis that includes a substance use disorder on the Shelter Plus Care Program Application Part 1, then you must answer "yes" to the above question.*]
Are you receiving services or treatment for the substance use disorder?
☐ Yes ☐ No

Do you have a diagnosis of HIV or AIDS?
☐ Yes ☐ No

If yes, is this a disabling condition?
☐ Yes ☐ No
[*If you stated that your disability is a diagnosis of HIV or AIDS on the Shelter Plus Care Program Application Part 1, then you must answer "yes" to the above question.*]
If yes, are you receiving services or treatment for HIV or AIDS?
☐ Yes ☐ No

Do you have a developmental disability?**
(**See definition of "developmental disability" at the end of this page.)
☐ Yes ☐ No

If yes, is the developmental disability a disabling condition?
☐ Yes ☐ No
[*If you stated that your disability is a developmental disability on the Shelter Plus Care Program Application Part 1, then you must answer "yes" to the above question.*]
If yes, are you receiving services or treatment for the developmental disability?
☐ Yes ☐ No

Do you have a chronic health condition*?**
(***See a list of some medical conditions that are considered chronic at the end of this page.)
☐ Yes ☐ No ☐ don't know

If yes, please specify what the condition is:

_____

If yes, is the chronic health condition a disabling condition?
☐ Yes ☐ No
If yes, are you receiving services or treatment for the chronic health condition?
☐ Yes ☐ No

Do you have a physical disability?
☐ Yes ☐ No ☐ don't know

If yes, please specify what the disability is:

_____

If yes, is the physical disability a disabling condition?
☐ Yes ☐ No
Are you receiving services or treatment for the physical disability?
☐ Yes ☐ No

*** "Disabling condition"** means a condition that is expected to be of long-continued and indefinite duration and is expected to substantially impede a person's ability to live independently.

**** "Developmental disability"** includes mental retardation, cerebral palsy, head injuries, autism, epilepsy, and some learning disabilities. Such conditions must have occurred before age 22 and be expected to continue indefinitely.

***** Chronic health conditions** include, but are not limited to, heart disease, including coronary heart disease, angina, heart attack and any other kind of heart condition or disease; severe asthma; diabetes; arthritis-related conditions including arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia; adult-onset cognitive impairments including traumatic brain injury, post-traumatic distress syndrome (PTSD), dementia, and other cognitive-related conditions; severe headache/migraine; cancer; chronic bronchitis; liver condition; stroke; or emphysema.

➢ SECTION 2. INFORMATION ABOUT OTHER ADULTS (Age 18+)

Fill out one Section 2 per other adult that will live in the Participant's household. Omit this section if there are no other adults in the household.

Participant Name: _____

Other Adult Name: _____

Social Security Number: _____ - _____ - _____

Date of Birth: _____ / _____ / _____

Race (check all that apply):
☐ American Indian/Alaska Native
☐ Asian
☐ Black/African-American
☐ Native Hawaiian/Other Pacific Islander
☐ White

Ethnicity:
☐ Hispanic
☐ non-Hispanic

Gender:
☐ female ☐ male
☐ transgender, male to female
☐ transgender, female to male

What is this adult's relationship to the Applicant?
☐ spouse ☐ significant other/partner
☐ parent ☐ step-parent ☐ grandparent
☐ aunt ☐ uncle
☐ brother ☐ sister
☐ son ☐ daughter ☐ step-child
☐ niece ☐ nephew
☐ roommate ☐ other

What is this adult's general physical health status?
☐ excellent ☐ very good ☐ good ☐ fair ☐ poor

Is this adult pregnant? ☐ Yes ☐ No No. of months: _____

.....

Last Permanent Address/Location:
☐ Check here if this adult's last permanent address zip code was the same as the Applicant's; if it was different, please fill it in below.

Zip Code _____

Did this adult spend the night in the same place as the Participant the night before the Application for Shelter Plus Care was filled out? ☐ Yes ☐ No

If the answer above is "no," where was this adult at that time?
☐ emergency shelter (includes a domestic violence shelter and a motel or hotel room paid for by an emergency shelter voucher)
☐ a place not meant for human habitation (car, park, etc.)
☐ transitional housing for homeless persons
☐ Safe Haven ☐ jail or prison
☐ substance abuse treatment facility or detox center
☐ hospital or other residential non-psychiatric medical facility
☐ psychiatric hospital or similar facility
☐ long-term care facility or nursing home
☐ other (specify: _____)

How long did this adult stay in the above situation?
☐ one day or less ☐ two days to one week
☐ more than one week but less than one month
☐ one to three months
☐ more than three months but less than one year
☐ one year or longer

Does this adult have health insurance? Please check all that apply.
☐ Medicare ☐ Medicaid (aka MO HealthNet)
☐ employer-provided health insurance
☐ health insurance obtained through COBRA
☐ VA Medical Services ☐ private pay insurance
☐ no insurance

If he/she has no health insurance, please state the reason why:
☐ applied; decision pending ☐ applied; not eligible
☐ have not applied

.....

Is this adult currently in school and/or working on any degree or certificate? ☐ Yes ☐ No

Has this adult received vocational training or received any apprenticeship certificates? ☐ Yes ☐ No

What is the highest grade completed by this adult?
☐ no school completed ☐ nursery school to 4th grade
☐ 5th grade to 6th grade ☐ 7th grade to 8th grade
☐ 9th grade ☐ 10th grade
☐ 11th grade ☐ 12th grade, no diploma
☐ high school diploma ☐ GED
☐ post-secondary education

Is this adult employed? ☐ Yes ☐ No

If yes, what type of employment is it?
☐ permanent ☐ temporary ☐ seasonal

How many hours did this adult work last week?

_____

If not employed, is this adult looking for work?
☐ Yes ☐ No

Other Adult Name: _____

Has this adult ever been a victim of domestic violence?
☐ Yes ☐ No ☐ don't know ☐ refuse to answer

If yes, how long in the past did this occur?
☐ Within past three months
☐ 3-6 months ago (excluding six months exactly)
☐ 6-12 months ago (excluding one year exactly)
☐ One year ago or more
☐ refused to answer

Is this adult currently fleeing domestic violence?
☐ Yes ☐ No ☐ don't know ☐ refused to answer

Does this adult have a mental illness?
☐ Yes ☐ No

If yes, is the mental illness a disabling condition?*
(*See definition of "disabling condition" at the end of this page.)
☐ Yes ☐ No

If yes, is this adult receiving services or treatment for the mental illness? ☐ Yes ☐ No

Does this adult have a substance use disorder?
☐ yes, alcohol use ☐ yes, drug use
☐ yes, both alcohol and drug use ☐ No

If yes, is the substance use disorder a disabling condition? ☐ Yes ☐ No

If yes, is this adult receiving services or treatment for the substance use disorder?
☐ Yes ☐ No

Does this adult have a diagnosis of HIV or AIDS?
☐ Yes ☐ No

If yes, is this a disabling condition?
☐ Yes ☐ No

If yes, is this adult receiving services or treatment for HIV or AIDS?
☐ Yes ☐ No

Does this adult have a developmental disability?**
(**See definition of "developmental disability" at the end of this page.)
☐ Yes ☐ No

If yes, is the developmental disability a disabling condition?
☐ Yes ☐ No

If yes, is this adult receiving services or treatment for the developmental disability?
☐ Yes ☐ No

Does this adult have a chronic health condition*?**
(***See a list of some medical conditions that are considered chronic at the end of this page.)
☐ Yes ☐ No ☐ don't know

If yes, please specify what the condition is:

_____

If yes, is the chronic health condition a disabling condition?
☐ Yes ☐ No

If yes, is this adult receiving services or treatment for the chronic health condition?
☐ Yes ☐ No

Does this adult have a physical disability?
☐ Yes ☐ No ☐ don't know

If yes, please specify what the disability is:

_____

If yes, is the physical disability a disabling condition?
☐ Yes ☐ No

If yes, is this adult receiving services or treatment for the physical disability?
☐ Yes ☐ No

*** "Disabling condition"** means a condition that is expected to be of long-continued and indefinite duration and is expected to substantially impede a person's ability to live independently.

**** "Developmental disability"** includes mental retardation, cerebral palsy, head injuries, autism, epilepsy, and certain learning disabilities. Such conditions must have occurred before age 22 and be expected to continue indefinitely.

***** Chronic health conditions** include, but are not limited to, heart disease, including coronary heart disease, angina, heart attack and any other kind of heart condition or disease; severe asthma; diabetes; arthritis-related conditions including arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia; adult-onset cognitive impairments including traumatic brain injury, post-traumatic distress syndrome (PTSD), dementia, and other cognitive-related conditions; severe headache/migraine; cancer; chronic bronchitis; liver condition; stroke; or emphysema.

➢SECTION 3. INFORMATION ABOUT MINORS (Age 17 and Under)

Fill out one Section 3 per minor that will live in the Participant's household. Omit this section if there are no minors in the household.

Participant Name: _____

Minor's Name: _____

Social Security Number: _____ - _____ - _____ **Date of Birth:** _____ / _____ / _____

Does the Participant have legal custody of this minor?
☐ Yes ☐ No

Race (check all that apply):
☐ American Indian/Alaska Native
☐ Asian
☐ Black/African-American
☐ Native Hawaiian/Other Pacific Islander
☐ White

Ethnicity:
☐ Hispanic
☐ non-Hispanic

Gender:
☐ female ☐ male
☐ transgender, male to female
☐ transgender, female to male

What is this minor's relationship to the Participant?
☐ brother ☐ sister
☐ son ☐ daughter ☐ step-child
☐ niece ☐ nephew ☐ grandchild
☐ other

What is this minor's general physical health status?
☐ excellent ☐ very good ☐ good ☐ fair ☐ poor

Is this minor pregnant? ☐ Yes ☐ No No. of months: __

.....

Last Permanent Address/Location:
☐ Check here if this minor's last permanent address zip code was the same as the Applicant's; if it was different, please fill it in below.

Zip Code _____

Did this minor spend the night in the same place as the Participant the night before the Application for Shelter Plus Care was filled out? ☐ Yes ☐ No

If the answer above is "no," where was this minor at that time?
☐ emergency shelter (includes a domestic violence shelter and a motel or hotel room paid for by an emergency shelter voucher)
☐ a place not meant for human habitation (car, park, etc.)
☐ transitional housing for homeless persons
☐ Safe Haven ☐ jail, prison, or juvenile detention facility
☐ substance abuse treatment facility or detox center
☐ hospital or other residential non-psychiatric medical facility
☐ psychiatric hospital or similar facility
☐ long-term care facility or nursing home
☐ Other (specify: _____)

How long did this minor stay in the above situation?
☐ one day or less ☐ two days to one week
☐ more than one week but less than one month
☐ one to three months
☐ more than three months but less than one year
☐ one year or longer

Does this minor have health insurance? Please check all that apply.
☐ Medicare ☐ Medicaid (aka MO HealthNet)
☐ State Children's Health Insurance Program (SCHIP)
☐ employer-provided health insurance
☐ health insurance obtained through COBRA
☐ VA Medical Services ☐ private pay insurance
☐ no insurance

If he/she has no health insurance, please state the reason why:
☐ applied; decision pending ☐ applied; not eligible
☐ have not applied

.....

Is this minor currently enrolled in school?
☐ Yes ☐ No ☐ the minor is not old enough

If yes, please give the name of the school:

_____

If yes, type of school: ☐ public ☐ parochial or private

If enrolled, is this minor connected with the school district's official homelessness coordinator?
☐ Yes ☐ No ☐ don't know

If not enrolled, give the most recent date of enrollment:

_____ / _____ / _____

If this minor is old enough to attend school but is not enrolled, please identify any problems or obstacles to enrollment:
☐ none
☐ residency requirements
☐ availability of school records
☐ birth certificate
☐ legal guardianship requirements
☐ transportation
☐ lack of available preschool programs
☐ immunization requirements
☐ physical examination records
☐ other

What is the highest grade completed by this minor?
☐ no school completed ☐ nursery school to 4th grade
☐ 5th grade to 6th grade ☐ 7th grade to 8th grade
☐ 9th grade ☐ 10th grade
☐ 11th grade ☐ 12th grade, no diploma
☐ high school diploma ☐ GED

Minor's Name: _____

Has this minor ever been a victim of domestic violence?
☐ Yes ☐ No ☐ don't know ☐ refused to answer

If yes, how long in the past did this occur?
☐ Within past three months
☐ 3-6 months ago (excluding six months exactly)
☐ 6-12 months ago (excluding one year exactly)
☐ One year ago or more
☐ refused to answer

Is this minor currently fleeing domestic violence?
☐ Yes ☐ No ☐ don't know ☐ refused to answer

Does this minor have a mental illness?
☐ Yes ☐ No

If yes, is the mental illness a disabling condition?*
(*See definition of "disabling condition" at the end of this page.)
☐ Yes ☐ No

If yes, is the minor receiving services or treatment for the mental illness? ☐ Yes ☐ No

Does this minor have a substance use disorder?
☐ yes, alcohol use ☐ yes, drug use
☐ yes, both alcohol and drug use ☐ No

If yes, is the substance use disorder a disabling condition? ☐ Yes ☐ No

If yes, is the minor receiving services or treatment for the substance use disorder?
☐ Yes ☐ No

Does this minor have a diagnosis of HIV or AIDS?
☐ Yes ☐ No

If yes, is this a disabling condition?
☐ Yes ☐ No

If yes, is the minor receiving services or treatment for HIV or AIDS?
☐ Yes ☐ No

Does this minor have a developmental disability?**
(**See definition of "developmental disability" at the end of this page.)
☐ Yes ☐ No

If yes, is the developmental disability a disabling condition?
☐ Yes ☐ No

If yes, is the minor receiving services or treatment for the developmental disability?
☐ Yes ☐ No

Does this minor have a chronic health condition*?**
(***See a list of some medical conditions that are considered chronic at the end of this page.)
☐ Yes ☐ No ☐ don't know

If yes, please specify what the condition is:

_____

If yes, is the chronic health condition a disabling condition?
☐ Yes ☐ No

If yes, is the minor receiving services or treatment for the chronic health condition?
☐ Yes ☐ No

Does this minor have a physical disability?
☐ Yes ☐ No ☐ don't know

If yes, please specify what the disability is:

_____

If yes, is the physical disability a disabling condition?
☐ Yes ☐ No

If yes, is the minor receiving services or treatment for the physical disability?
☐ Yes ☐ No

*** "Disabling condition"** means a condition that is expected to be of long-continued and indefinite duration and is expected to substantially impede a person's ability to live independently.

**** "Developmental disability"** includes mental retardation, cerebral palsy, head injuries, autism, epilepsy, and certain learning disabilities. Such conditions must have occurred before age 22 and be expected to continue indefinitely.

***** Chronic health conditions** include, but are not limited to, heart disease, including coronary heart disease, angina, heart attack and any other kind of heart condition or disease; severe asthma; diabetes; arthritis-related conditions including arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia; adult-onset cognitive impairments including traumatic brain injury, post-traumatic distress syndrome (PTSD), dementia, and other cognitive-related conditions; severe headache/migraine; cancer; chronic bronchitis; liver condition; stroke; or emphysema.

➢SECTION 4. INCOME

CASH INCOME

Do you or anyone who will live with you receive cash income from any source currently? ☐ Yes ☐ No

If yes, please check the boxes next to all sources of **CASH** income in the list below received by all household members (do not include food stamps); indicate which household member actually receives the income; and state the amount received per month.

Type	Names of Persons Who Have the Cash Income	Amount/Month
☐ Employment income	_____	$ _____
	_____	$ _____
☐ Unemployment Insurance	_____	$ _____
☐ Supplemental Security Income (SSI)	_____	$ _____
	_____	$ _____
☐ Social Security Disability (SSDI)	_____	$ _____
	_____	$ _____
☐ VA Service-Connected Disability Comp.	_____	$ _____
☐ Private disability insurance	_____	$ _____
☐ Worker's Compensation	_____	$ _____
☐ TANF	_____	$ _____
☐ Social Security retirement	_____	$ _____
☐ VA Non-Service Disability Pension	_____	$ _____
☐ Pension or retirement from a former job (includes military pension)	_____	$ _____
☐ Child support	_____	$ _____
☐ Alimony or other spousal support	_____	$ _____

☐ Other sources of income: **specify any other sources of cash income, monthly amount, and who has the income, below:**

_____

_____

NON-CASH BENEFITS

Do you or anyone who will live with you receive non-cash benefits or services currently? ☐ Yes ☐ No

Please check the boxes next to all sources of **NON-CASH** benefits and services, and give the name of the household member who has or receives the benefits/services. For food stamps/EBT/SNAP, provide the amount received per month.

Type	Names of Persons Who Have the Non-Cash Benefits	Amount/Month
☐ Food stamps/EBT/SNAP	_____	$ _____
	_____	
	_____	
☐ WIC	_____	
☐ VA Medical Services	_____	
☐ TANF childcare services	_____	
☐ TANF transportation services	_____	
☐ Other TANF-funded services	_____	
☐ Other sources	_____	
	_____	
	_____	

➢SECTION 5. VETERAN STATUS

Is anyone in this household a veteran? ☐ Yes ☐ No

If yes, name: _____
If more than one veteran is in the household, please use additional copies of this page.

<u>If no, skip the rest of this section.</u>

What date did the veteran begin military service? _____ / _____ / _____

What branch was served in?
☐ Army ☐ Air Force ☐ Navy ☐ Marines ☐ Other ☐ don't know

When was the service? Choose one; if the service dates overlap two choices, choose the one containing most of the service time.

☐ Post-September 11th (September 11, 2001-present)

☐ Persian Gulf (August 1991-September 10, 2001)

☐ Post-Vietnam (May 1975-July 1991)

☐ Vietnam (August 1964-April 1975)

☐ Between Korea and Vietnam (Feb. 1955-July 1964)

☐ Korea (June 1950-January 1955)

☐ Between WW2 and Korea (August 1947-May 1950)

☐ WW2 (September 1940-July 1947)

☐ Don't know

Duration of Active Duty: _____ (enter number of months served)

Was the service in a war zone? ☐ Yes ☐ No ☐ don't know

If yes, which one?

☐ Europe ☐ North Africa ☐ Vietnam

☐ Laos and Cambodia ☐South China Sea

☐ China, Burma, India ☐ Korea ☐ South Pacific

☐ Persian Gulf ☐ Afghanistan ☐ Don't know

Number of months in war zone: _____

Did the veteran receive fire, either hostile or friendly? ☐ Yes ☐ No ☐ don't know

Discharge Status:

☐ Honorable ☐ General ☐ Medical

☐ Bad Conduct ☐ Dishonorable

☐ Other ☐ don't know ☐ refused to answer

--

If the Participant is in St. Louis City, St. Louis County, Jackson County, or St. Joseph (including Andrew, Buchanan and DeKalb Counties), you are done—skip the next page. If the client is anywhere else, the next page must also be filled out.

HOMELESS MISSOURIANS INFORMATION SYSTEM

Notice of Client Rights

The information that is collected in the HMIS database is protected by limiting access to the database and by limiting with whom the information may be shared, in compliance with applicable federal and state laws. Every person and agency that is authorized to read or enter information into the database has signed an agreement to maintain the security and confidentiality of the information. Any person or agency that is found to violate their agreement may have their access rights terminated and may be subject to further penalties.

FOR DATA BEING ENTERED INTO THE HMIS I UNDERSTAND THAT:

- Staff of other agencies who will see my information have promised to protect it.
- Others using HMIS will protect my information.
- Information I give about physical or mental health problems will not be shared with others.
- Partner Agencies may share information that does not identify me to others.
- I have the right to request who has looked at my file.
- I understand I have the right to ask, "Can I refuse to answer that question," and how my refusal might affect my receipt of services.
- I have the right to view confidentiality policies used by HMIS.
- If I receive assistance through the Supportive Services for Veteran Families (SSVF) Program that my personally identifying information will be exported from HMIS and uploaded to a Veterans Administration (VA) Repository to meet VA-required reporting.
- Another Partner Agency may enter my data into HMIS and therefore may retain the paper copy file.
- If I decide at a later date that I no longer want my information in HMIS, I can request that it be archived.
- ***I am responsible for making all household members aware their information will be entered in HMIS and they have the option to contact this agency with any questions or concerns.***

_____	_____	_____
Client Name (*please print*)	Client Signature	Date
_____	_____	_____
Agency Personnel Name (*please print*)	Agency Personnel Signature	Date