

Nebraska HMIS Intake Form

Participant ID (STAFF ONLY)

SOCIAL SECURITY NUMBER

NAME	
First Name	
Middle Name	
Last Name	
Suffix (Jr., III)	
Maiden/Alias	

DATE OF BIRTH

GENDER	
<input type="checkbox"/> Female	<input type="checkbox"/> Male
<input type="checkbox"/> Transgender Female	<input type="checkbox"/> Transgender Male
<input type="checkbox"/> Questioning	<input type="checkbox"/> Other: _____

RACE	
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
<input type="checkbox"/> White	<input type="checkbox"/> Other: _____

ETHNICITY	
<input type="checkbox"/> Non-Hispanic / Non-Latin(a)(o)(x)	<input type="checkbox"/> Hispanic/Latin(a)(o)(x)

CONTACT INFORMATION	
Street Address:	
City:	
State:	Zip:
County of Current Residence:	
County of Legal Residence:	
Phone Number:	
Email Address:	

Is this request COVID-19 related?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

U.S. MILITARY VETERAN	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Do you struggle with any of the following?			
Substance Abuse	<input type="checkbox"/> Alcohol <input type="checkbox"/> Drug	HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Developmental Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Physical Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	Long Term?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	Long Term?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mental Health	<input type="checkbox"/> Yes <input type="checkbox"/> No	Long Term?	<input type="checkbox"/> Yes <input type="checkbox"/> No

HOUSING STATUS	
<input type="checkbox"/> Category 1 – Homeless	<input type="checkbox"/> Category 2 – At imminent Risk of losing housing
<input type="checkbox"/> Category 3 – Homeless under other federal statutes	<input type="checkbox"/> Category 4 – Fleeing violence
<input type="checkbox"/> At-risk of homelessness	<input type="checkbox"/> Stably housed

RELATIONSHIP TO HEAD OF HOUSEHOLD	
<input type="checkbox"/> Self (head of household)	<input type="checkbox"/> Head of household's spouse/partner
<input type="checkbox"/> Head of household's child	<input type="checkbox"/> Head of household's other relation
<input type="checkbox"/> Other: _____	

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PRIOR LIVING SITUATION – SELECT ONE		
HOMELESS		
<input type="checkbox"/> Place not meant for habitation (car, etc.)	<input type="checkbox"/> Emergency shelter, hotel/motel voucher	<input type="checkbox"/> Safe Haven
INSTITUTIONAL		
<input type="checkbox"/> Foster care home	<input type="checkbox"/> Hospital or medical facility	<input type="checkbox"/> Jail, prison, or juvenile detention
<input type="checkbox"/> Long-term care facility or nursing home	<input type="checkbox"/> Psychiatric hospital/facility	<input type="checkbox"/> Substance abuse trmt. center
HOUSING		
<input type="checkbox"/> Residential Project/halfway house	<input type="checkbox"/> Self-paid hotel/motel	<input type="checkbox"/> Housing for homeless (transitional)
<input type="checkbox"/> Host Home	<input type="checkbox"/> Friend's room/house	<input type="checkbox"/> Family member's room/house
<input type="checkbox"/> Rental, GPD TIP subsidy	<input type="checkbox"/> Rental, VASH subsidy	<input type="checkbox"/> Permanent Housing
<input type="checkbox"/> Rental, RRH subsidy	<input type="checkbox"/> Rental, HVC voucher	<input type="checkbox"/> Rental, public housing
<input type="checkbox"/> Rental, no ongoing subsidy	<input type="checkbox"/> Rental, other subsidy	<input type="checkbox"/> Owned, with subsidy
<input type="checkbox"/> Owned, no subsidy	<input type="checkbox"/> Interim Housing (retired)	
LENGTH OF STAY IN PRIOR LIVING SITUATION		
<input type="checkbox"/> 1 night or less	<input type="checkbox"/> 2 to 6 nights	
<input type="checkbox"/> 1 week or more, but less than 1 month	<input type="checkbox"/> 1 month or more, but less than 90 days	
<input type="checkbox"/> 90 days or more, but less than 1 year	<input type="checkbox"/> 1 year or more	
On the night before entering living situation, did you stay on the streets, or in an emergency shelter?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		

Answer the following if homeless, or been homeless:

Date homelessness started:	
How many TIMES been homeless, on the streets, or in an emergency shelter in the past 3 years?	
<input type="checkbox"/> One time	<input type="checkbox"/> Two Times
<input type="checkbox"/> Three Times	<input type="checkbox"/> Four or more times
How many MONTHS been homeless, on the streets, or in an emergency shelter in the past 3 years?	
<input type="checkbox"/> One or less	<input type="checkbox"/> 2 to 12 months (# of months: _____)
<input type="checkbox"/> More than 12 months	

HEALTH INSURANCE – Are you covered by Health Insurance?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Health Insurance Type	
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare
<input type="checkbox"/> State Children's Health Insurance Program	<input type="checkbox"/> Veteran's Administration (VA) Medical Services
<input type="checkbox"/> Employer-Provided	<input type="checkbox"/> COBRA
<input type="checkbox"/> Private Pay Health Insurance	<input type="checkbox"/> State Health Insurance
<input type="checkbox"/> Indian Health Services Program	<input type="checkbox"/> Other: _____

FOSTER CARE – As a child, were you ever in Foster Care or are you now?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

DOMESTIC VIOLENCE – Are you a domestic violence victim/survivor?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, when did the experience occur?	
<input type="checkbox"/> Within past three months	<input type="checkbox"/> Three to six months ago
<input type="checkbox"/> 6 to twelve months ago	<input type="checkbox"/> More than a year ago
If yes, are you currently fleeing?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

EDUCATION – Highest level of school completed	
<input type="checkbox"/> No schooling	<input type="checkbox"/> Nursery to 4 th grade
<input type="checkbox"/> 5 th or 6 th grade	<input type="checkbox"/> 7 th or 8 th grade
<input type="checkbox"/> 9 th grade	<input type="checkbox"/> 10 th grade
<input type="checkbox"/> 11 th grade	<input type="checkbox"/> 12 th
<input type="checkbox"/> High school diploma	<input type="checkbox"/> GED
<input type="checkbox"/> Post-secondary school	

SEXUAL ORIENTATION	
<input type="checkbox"/> Heterosexual	<input type="checkbox"/> Gay
<input type="checkbox"/> Lesbian	<input type="checkbox"/> Bisexual
<input type="checkbox"/> Questioning/Unsure	<input type="checkbox"/> Other: _____

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INCOME AND SOURCES - Does the client currently have any income from any source?			
<input type="checkbox"/> Yes		<input type="checkbox"/> No	
Source of Income	Yes	No	If yes, monthly amount from source (round to nearest dollar)
Earned Income (from job)	<input type="checkbox"/>	<input type="checkbox"/>	\$
Unemployment Insurance	<input type="checkbox"/>	<input type="checkbox"/>	\$
SSI	<input type="checkbox"/>	<input type="checkbox"/>	\$
SSDI	<input type="checkbox"/>	<input type="checkbox"/>	\$
VA Service Connected Disability Compensation	<input type="checkbox"/>	<input type="checkbox"/>	\$
VA Non-service Connected Disability Pension	<input type="checkbox"/>	<input type="checkbox"/>	\$
Private Disability Insurance	<input type="checkbox"/>	<input type="checkbox"/>	\$
Worker's Compensation	<input type="checkbox"/>	<input type="checkbox"/>	\$
TANF	<input type="checkbox"/>	<input type="checkbox"/>	\$
General Assistance	<input type="checkbox"/>	<input type="checkbox"/>	\$
Retirement Income from Social Security	<input type="checkbox"/>	<input type="checkbox"/>	\$
Pension or Retirement Income from a Former Job	<input type="checkbox"/>	<input type="checkbox"/>	\$
Child Support	<input type="checkbox"/>	<input type="checkbox"/>	\$
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	\$
Total monthly income from all sources			\$

NON-CASH BENEFITS - Does the client have any non-cash benefits from any source?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
Source of Non-Cash Benefit	Yes	No
LIHEAP	<input type="checkbox"/>	<input type="checkbox"/>
Supplemental Nutrition Assistance Program (SNAP)	<input type="checkbox"/>	<input type="checkbox"/>
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	<input type="checkbox"/>	<input type="checkbox"/>
TANF Child Care Services	<input type="checkbox"/>	<input type="checkbox"/>
TANF Transportation Services	<input type="checkbox"/>	<input type="checkbox"/>
Other TANF-funded Services	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>

Community Response and Homeless Management Information System (HMIS) Services Consumers Informed Consent & Release of Information Authorization

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, gender, race, 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

As part of the evaluation of Community Response and the Connected Youth Initiative, your data will be shared with Nebraska Children and their evaluators from Munroe-Meyer Institute. Your name will not be included in any of the information that is provided to the evaluation team. All data is summarized as a group. You can choose not to participate in the evaluation. If you have questions, please call Dr. Amanda Prokasky at 402-552-6865.

The Buffalo County Community Response Team (BCCRT) is a collaborative approach to connecting households needing assistance with basic needs and/or experiencing housing stressors (e.g., unable to meet rental or utility obligations, facing eviction, fleeing domestic violence, or other unstable housing situations) with support and financial assistance. By signing this form, I authorize the following:

- consent to share information with agencies and partners of the BCCRT who are reviewing my application and providing financial assistance and other services.
- consent for the agencies that comprise the BCCRT to discuss the information for the purpose of assessing my/our needs for housing, utility assistance, food, counseling, legal services, coaching, and/or other services.

I agree to have my information shared for the evaluation. _____ YES _____ NO

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

- 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.

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Buffalo County Community Response Participant Information

Please complete all of the following information:

Date:							
Full Name:							
How else can we help? What are your most urgent needs? Check all that apply.		<input type="checkbox"/> Daily living		<input type="checkbox"/> Mental Health			
		<input type="checkbox"/> Dentist		<input type="checkbox"/> Parenting Assistance			
		<input type="checkbox"/> Education		<input type="checkbox"/> Physical Health			
		<input type="checkbox"/> Employment		<input type="checkbox"/> Substance Use			
		<input type="checkbox"/> Finances		<input type="checkbox"/> Supportive Relationships			
		<input type="checkbox"/> General Life Skills		<input type="checkbox"/> Transportation			
		<input type="checkbox"/> Housing		<input type="checkbox"/> Utilities			
		<input type="checkbox"/> Legal Help		<input type="checkbox"/> Other: _____			
I am currently receiving the following services and supports (check all that apply):		<input type="checkbox"/> Education Services		<input type="checkbox"/> Mental Health Services			
		<input type="checkbox"/> Employment Services		<input type="checkbox"/> Substance Use Services			
		<input type="checkbox"/> Food Services		<input type="checkbox"/> Transportation Services			
		<input type="checkbox"/> Housing Services		<input type="checkbox"/> Other Specify: _____			
		<input type="checkbox"/> Legal Services		<input type="checkbox"/> Not applicable/None			
		<input type="checkbox"/> Medical Services		<input type="checkbox"/> Prefer Not to Answer			
I am currently receiving the following types of public assistance (check all that apply):		<input type="checkbox"/> Aid to Dependent Children/TANF		<input type="checkbox"/> Utilities Assist/LIHEAP			
		<input type="checkbox"/> Childcare subsidy/Title XX		<input type="checkbox"/> WIC			
		<input type="checkbox"/> Food Stamps (SNAP)		<input type="checkbox"/> Other: _____			
		<input type="checkbox"/> Housing Voucher/Section 8		<input type="checkbox"/> NA/None			
		<input type="checkbox"/> Medicaid		<input type="checkbox"/> Prefer Not to Answer			
		<input type="checkbox"/> Unemployment					
Is there someone who doesn't live with you we can contact if we can't reach you?							
<input type="checkbox"/> Yes, please list below		<input type="checkbox"/> No		<input type="checkbox"/> Unsure			
				<input type="checkbox"/> Prefer not to say			
Name		Relationship to you		Phone			
Do you or your children QUALIFY for Medicaid, Title XX, and/or free and reduced lunch, even if you don't receive any of them?				<input type="checkbox"/> Yes			
				<input type="checkbox"/> Unsure			
Do you have enough people to count on when you need someone to give you good advice?				<input type="checkbox"/> No			
				<input type="checkbox"/> Prefer Not to Say			
				<input type="checkbox"/> If yes, how many: _____			
As of today's date are you between the ages of 14 and 25 (have not yet had your 26th birthday)?*				<input type="checkbox"/> Yes			
				<input type="checkbox"/> No			
ONLY if you are between the ages of 14 and 25 (answered "yes above), have you experienced any of the following?							
<input type="checkbox"/> Foster care/state ward/placed outside of home		<input type="checkbox"/> In-home services for your family (from DHHS)		<input type="checkbox"/> Guardianship or Adoption			
				<input type="checkbox"/> Probation or Incarceration			
<input type="checkbox"/> Homelessness		<input type="checkbox"/> Human Trafficking		<input type="checkbox"/> Prefer not to say			
				<input type="checkbox"/> N/A, no experience with any			
Are you currently pregnant or expecting a child? (mother or father)				<input type="checkbox"/> Yes			
				<input type="checkbox"/> Unsure			
				<input type="checkbox"/> No			
				<input type="checkbox"/> Prefer Not to Say			
Including yourself, how many ADULTS (people 18+) are in your household?							
How many CHILDREN (people 17 and younger) are in your household? Enter 0 if no children live with you.							
Do any of your children have a disability?				<input type="checkbox"/> Yes			
				<input type="checkbox"/> No			
				<input type="checkbox"/> If yes, how many: _____			

Information to be completed by the referral agency:

Referral Agency:	
Contact Phone Number:	
Referral Staff Member Name:	
Contact Email Address:	

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Buffalo County Community Response Participant Information

INSTRUCTIONS: All parts of the Participant Information Survey should be completed at the start of participation in Community Response or the Connected Youth Initiative. The form may be completed with the assistance of a Central Navigator or other service provider, if needed.

For each of the following, mark the response that most closely matches how you feel.

Please complete all of the following information:						
Date:						
Full Name:						
SOCIAL CONNECTIONS	A. NOT AT ALL LIKE MY LIFE	B. NOT MUCH LIKE MY LIFE	C.SOMEWHAT LIKE MY LIFE	D. QUITE A LOT LIKE MY LIFE	E. JUST LIKE MY LIFE	N/A I DO NOT HAVE KIDS
I have people who believe in me.						
I have someone in my life who gives me advice, even when it's hard to hear.						
When I am trying to work on achieving a goal, I have friends who will support me.						
When I need someone to look after my kids on short notice, I can find someone I trust						
I have people I trust to ask for advice about: (check all that apply)	<input type="checkbox"/> Money/Bills/Budgeting <input type="checkbox"/> Relationships and/or my love life <input type="checkbox"/> Food/Nutrition			<input type="checkbox"/> Stress, Anxiety, and/or Depression <input type="checkbox"/> Parenting/My kids (if applicable) <input type="checkbox"/> None of the above		
CONCRETE SUPPORTS	A. NOT AT ALL LIKE MY LIFE	B. NOT MUCH LIKE MY LIFE	C.SOMEWHAT LIKE MY LIFE	D. QUITE A LOT LIKE MY LIFE	E. JUST LIKE MY LIFE	
I was able to cover all my expenses last month (expenses include costs like rent, utility bills, food, transportation, child care, and medical expenses)						
The transportation I use is reliable and consistent						
My housing situation is affordable, safe, and stable						
Over the past three months, my children and I have been able to see a doctor when we needed to. (If you do not have children, answer for just yourself)						
Over the past three months, I have found a job and/or worked when I needed to						

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Buffalo County Community Response Flex Fund Form

Please attach/send any leases, bills, and documents with this form.

Please complete all of the following information:	
Date:	
Full Name:	
How can we help? What is your need? About how much does it cost? Please include as many details as you can.	
Where should we send the payment? – will be required to complete a W9	
Vendor Name	
Vendor Contact Name	
Vendor Phone Number	
Vendor Address	

Please indicate any support you have received from the following agencies, if any, in the blanks below:			
Community Action: _____	Jubilee Center: _____	DHHS: _____	S.A.F.E. Center: _____
Salvation Army: _____	NE ERA Program: _____	Other: (Agency: _____ Amount: _____)	
Total Amount Requested from Flex Funds			
Do you struggle with any of the following?	<input type="checkbox"/> Injured Brain	<input type="checkbox"/> Language Barriers	<input type="checkbox"/> Emotional Neglect
Are you willing to meet with a coach to support your goals?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, please explain: _____			

IN OFFICE USE ONLY			
Date of Payment:		Payment Method: <input type="checkbox"/> Check <input type="checkbox"/> Credit Card	
		<input type="checkbox"/> Gift Card <input type="checkbox"/> Other: _____	
Housing Amount:	Detailed need:	Employment Amount:	Detailed need:
Utilities Amount:	Detailed need:	Physical/Dental amount:	Detailed need:
Daily Living Amount:	Detailed need:	Mental Health Amount:	Detailed need:
Education Amount:	Detailed need:	Parenting Amount:	Detailed need:
Transportation Amount:	Detailed need:	Other/Coaching Amount:	Detailed need: