

HMIS Update Form

Client Name: _____ **SSN:** _____ **Date of Birth:** ____/____/____

Agency or Program Name: _____ **Date Effective:** ____/____/____

Case Manager Name: _____ **Email:** _____ **Phone:** () _____

Employment Status		
Client has had recent changes in: <input type="checkbox"/> Employment Status <input type="checkbox"/> Income/Health Insurance <input type="checkbox"/> Disability Status <input type="checkbox"/> Housing Status	Is client employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Hours per week? _____ Where? _____
	If <u>unemployed</u>, why? <input type="checkbox"/> Looking for work <input type="checkbox"/> Unable to work <input type="checkbox"/> Not looking for work	

Monthly Income				
	Received in Past 30 Days?		Received in Past 30 Days?	
\$ _____ Earned income (i.e. employment income)	Yes / No		\$ _____ VA service-connected disability compensation	Yes / No
\$ _____ Pension from a former job (including military retirement pay)	Yes / No		\$ _____ VA non service-connected disability pension	Yes / No
\$ _____ Private disability insurance	Yes / No		\$ _____ Alimony or other spousal support	Yes / No
\$ _____ Child support	Yes / No		\$ _____ SSI	Yes / No
\$ _____ Unemployment insurance	Yes / No		\$ _____ SSDI	Yes / No
\$ _____ Worker's compensation	Yes / No		\$ _____ General Assistance	Yes / No
\$ _____ Retirement income from Social Security	Yes / No		\$ _____ TANF	Yes / No
			\$ _____ Other income source: _____	Yes / No

Non Cash Benefits				
	Received in Past 30 Days?		Received in Past 30 Days?	
- Supplemental Nutrition Assistance Program (Food stamps)	Yes / No		-- Other TANF-funded services	Yes / No
- TANF Child Care Services	Yes / No		- WIC	Yes / No
- TANF Transportation Services	Yes / No		- Other _____	Yes / No

Health Insurance				
	Currently Covered?	HOPWA: If no, reason?	Currently Covered?	HOPWA: If no, reason?
Medicaid/Medi-Cal	Yes / No	_____	Health insurance obtained through COBRA	Yes / No _____
MEDICARE	Yes / No	_____	Private Pay Health Insurance	Yes / No _____
State Children's Health Insurance Program (SCHIP)	Yes / No	_____	State Health Insurance for Adults	Yes / No _____
Veteran's Administration (VA) Medical Services	Yes / No	_____	Indian Health Services Program	Yes / No _____
Employer-provided Health Insurance	Yes / No	_____	Other _____	Yes / No _____

Disabilities (please answer Yes or No to each of the following)					
Physical	Yes / No	Long Term and Impairs Independence?	Yes / No	Mental health disorder	Yes / No
Developmental	Yes / No			Alcohol use disorder	Yes / No
Chronic health condition	Yes / No	Long Term and Impairs Independence?	Yes / No	Drug use disorder	Yes / No
HIV/AIDS	Yes / No			Both Alcohol and Drug disorders	Yes / No

Well-Being -Use the scale provided for each set of questions. You may also use Client doesn't know (DK) or Client refused(R)

Strongly disagree (0), Somewhat disagree (1), Neither agree or disagree (2), Somewhat agree (3), Strongly agree (4),	Client perceives their life has value and worth _____
	Client perceives they have support from others who will listen to problems _____
	Client perceives they have a tendency to bounce back after hard times _____
Not at all (0) , Once a month (1) , Several times a month (2), Several times a week (3), At least every day (4)	Client's frequency of feeling nervous, tense, worried, frustrated, or afraid _____

Housing Placement or New Housing Situation		
<input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Permanent housing for formerly homeless persons (such as CoC project; HUD legacy programs; or HOPWA PH) <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Place not meant for habitation (vehicle, abandoned bldg, train station/airport, or anywhere outside)	<input type="checkbox"/> Jail, prison, or juvenile detention facility <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Rental by client, with GPD TIP housing subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> Staying or living with friends, temporary tenure (e.g. room, apartment or house) <input type="checkbox"/> Safe haven	<input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Host home (non-crisis) <input type="checkbox"/> Other _____ <input type="checkbox"/> Client doesn't know refused

Housing Move-in Date: ____/____/____ (PSH and RRH programs must enter this in the HMIS intake screen)	* If Move-in Date, Specify City Where Housed: City _____	New Permanent Housing Address _____ State _____ Zip _____
--	--	---