

Contra Costa HMIS Project
HMIS Update Form

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

Program _____ Date Effective: ____/____/____

Client has had recent changes in their: <input type="checkbox"/> Employment Status <input type="checkbox"/> Income/Health Insurance <input type="checkbox"/> Disability Status <input type="checkbox"/> Housing Status	Employment Status		
	Is client Employed or Unemployed? <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed	If employed, type of employment? <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal Hours per week? _____ Where? _____	If unemployed, 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 (ie. employment income)	Yes / No	\$ _____ Alimony or other spousal support	Yes / No
\$ _____ Retirement income from Social Security	Yes / No	\$ _____ SSI	Yes / No
\$ _____ Pension from a former job (including military retirement pay)	Yes / No	\$ _____ SSDI	Yes / No
\$ _____ Private disability insurance	Yes / No	\$ _____ General Assistance	Yes / No
\$ _____ Child support	Yes / No	\$ _____ TANF	Yes / No
\$ _____ Unemployment insurance	Yes / No	\$ _____ Other Income Source: _____	
\$ _____ Worker's compensation	Yes / No	<input type="checkbox"/> No Financial Resources	
\$ _____ VA service-connected disability compensation	Yes / No		
\$ _____ VA non service-connected disability pension	Yes / No		
Total Monthly Income: \$ _____ (please indicate if \$0)			

Non Cash Benefits	Health Insurance
Received in Past 30 Days?	Currently covered? *HOPWA: If no, reason?
- Supplemental Nutrition Assistance Program (Food stamps) Yes / No - TANF Child Care Services Yes / No - TANF Transportation Services Yes / No - Other TANF-funded services Yes / No - WIC Yes / No - Section 8, public housing, or other ongoing rental assistance Yes / No - Temporary rental assistance Yes / No - Other _____ Yes / No	- Medicaid/Medi-Cal Yes / No - MEDICARE Yes / No - State Children's Health Insurance Program (SCHIP) Yes / No - Veteran's Administration (VA) Medical Services Yes / No - Employer-provided Health Insurance Yes / No - Health insurance obtained through COBRA Yes / No - Private Pay Health Insurance Yes / No - State Health Insurance for Adults Yes / No - Indian Health Services Program Yes / No
*HOPWA Only: If not covered, indicate reason (A= Applied but decision pending, B = Applied but client was ineligible, C = Client did not apply, D = Insurance Type not applicable.)	

Disabilities														
	Yes/No	Severity Documented?	Long Term?	Receiving Aid?		Yes/No	Severity Documented?	Long Term?	Receiving Aid?		Yes/No	Severity Documented?	Long Term?	Receiving Aid?
1. Mental Health Problem _____	_____	_____	_____	_____	4. HIV/AIDS _____	_____	_____	_____	_____	7. Chronic Health Condition _____	_____	_____	_____	_____
2. Alcohol Abuse _____	_____	_____	_____	_____	5. Physical _____	_____	_____	_____	_____	8. Other: _____	_____	_____	_____	_____
3. Drug Abuse _____	_____	_____	_____	_____	6. Developmental _____	_____	_____	_____	_____		_____	_____	_____	_____
Note: Chronic health condition – a diagnosed condition that is more than three months in duration and is either not curable or has residual effects that limit daily living and require adaptation in function or special assistance. Examples include but are not limited to: heart disease, severe asthma, diabetes, arthritis-related conditions, adult onset cognitive impairments (including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive related conditions), severe headache/migraine, cancer, chronic bronchitis, liver condition, stroke, or emphysema.														

Housing Status Updates		
Housing Status: <input type="checkbox"/> Category 1 – Homeless (i.e. streets, shelter, transitional housing) <input type="checkbox"/> Category 2 – At imminent risk of losing housing (within 14 days) <input type="checkbox"/> Category 3 – Homeless only under other federal statutes <input type="checkbox"/> Category 4 – Fleeing domestic violence <input type="checkbox"/> At-risk of homelessness <input type="checkbox"/> Stably housed <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused		
Housing Placement or New Housing Situation: <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher <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"/> Safe haven </div> <div style="width: 30%;"> <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 in a friend's room, apartment or house </div> <div style="width: 30%;"> <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"/> Other _____ <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused </div> </div>		
* If client moved into a permanent housing situation, Move-in Date: ____/____/____ (mm/dd/yy) Address: _____ City _____ State _____ Zip _____ If client entered into a Program, Program Name: _____		

For HOPWA Programs

Receiving Public HIV/AIDS Medical Assistance? Yes / No

If no, reason?

- | | |
|---|---|
| <input type="checkbox"/> Applied: decision pending | <input type="checkbox"/> Insurance type N/A for this client |
| <input type="checkbox"/> Applied: client not eligible | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Client did not apply | <input type="checkbox"/> Client refused |

Receiving AIDS Drug Assistance Program (ADAP)? Yes / No

If no, reason?

- | | |
|---|---|
| <input type="checkbox"/> Applied: decision pending | <input type="checkbox"/> Insurance type N/A for this client |
| <input type="checkbox"/> Applied: client not eligible | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Client did not apply | <input type="checkbox"/> Client refused |

* Note: PATH Programs should use the PATH Contact/Update Sheet to record updates.