HMIS Update Form

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

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

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

Client has had recent changes in:
- ❑ Employment Status
- ❑ Income/Health Insurance
- ❑ Disability Status
- ❑ Housing Status

Employment Status

Is client **employed** or **unemployed**?
- ❑ Employed
- ❑ Unemployed

If **employed**, type of employment?
- ❑ Full Time
- ❑ Part Time
- ❑ Seasonal

Hours per week? _____

Where? _____

If **unemployed**, why?
- ❑ Looking for work
- ❑ Unable to work
- ❑ Not looking for work

Monthly Income

	Received in Past 30 Days?
$_____Earned income (i.e. employment income)	Yes / No
$_____Pension from a former job (including military retirement pay)	Yes / No
$_____Private disability insurance	Yes / No
$_____Child support	Yes / No
$_____Unemployment insurance	Yes / No
$_____Worker's compensation	Yes / No
$_____Retirement income from Social Security	Yes / No
$_____VA service-connected disability compensation	Yes / No
$_____VA non service-connected disability pension	Yes / No
$_____Alimony or other spousal support	Yes / No
$_____SSI	Yes / No
$_____SSDI	Yes / No
$_____General Assistance	Yes / No
$_____TANF	Yes / No
$_____ Other income source: _____	Yes / No

Non Cash Benefits

	Received in Past 30 Days?
- 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
- Other _____	Yes / No

Health Insurance

	Currently Covered?	HOPWA: If no, reason?
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	_____
Other _____	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 (please answer Yes or No to each of the following)

Physical	Yes / No	Long Term and Impairs Independence?	Yes / No	Mental health problem	Yes / No	Long Term and Impairs Independence?	Yes / No
Developmental	Yes / No			Alcohol abuse	Yes / No	Long Term and Impairs Independence?	Yes / No
Chronic health condition	Yes / No	Long Term and Impairs Independence?	Yes / No	Drug abuse	Yes / No	Long Term and Impairs Independence?	Yes / No
HIV/AIDS	Yes / No			Both Alcohol and Drug Abuse	Yes / No	Long Term and Impairs Independence?	Yes / No

Housing Status Updates

Housing Placement or New Housing Situation:

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

*** For RRH and PH use only, Housing Move-in Date:**
_____/_____/_____
(mm/dd/yy)

*** If Move-in Date, Specify City Where Housed:**

City _____

New Permanent Housing Address
_____
State _____ Zip _____

For HOPWA Programs

Receiving Public HIV/AIDS Medical Assistance? Y / N

If no, reason?
- ❑ Applied; decision pending
- ❑ Applied; client not eligible
- ❑ Client did not apply
- ❑ Insurance type N/A for this client
- ❑ Client doesn't know
- ❑ Client refused

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

If no, reason?
- ❑ Applied; decision pending
- ❑ Applied; client not eligible
- ❑ Client did not apply
- ❑ Insurance type N/A for this client
- ❑ Client doesn't know
- ❑ Client refused