HMIS Update Form

***If your client has had changes in Employment Status, Income, Health Insurance, Disability Status, or Housing Status or Placement, please fill out all sections below with the most up-to-date information.**

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

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

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

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	Long Term and Impairs Independence?	Yes / No
Developmental	Yes / No			Alcohol use disorder	Yes / No	Long Term and Impairs Independence?	Yes / No
Chronic health condition	Yes / No	Long Term and Impairs Independence?	Yes / No	Drug use disorder	Yes / No	Long Term and Impairs Independence?	Yes / No
HIV/AIDS	Yes / No			Both Alcohol and Drug disorders	Yes / No	Long Term and Impairs Independence?	Yes / No

Are you a survivor of domestic violence? ❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer

If yes, please indicate when the most recent domestic violence experience occurred:

❑ Within the past 3 months ❑ 3-6 months ago ❑ 6-12 months ago ❑ One year ago or more ❑ Client doesn't know ❑ Client prefers not to answer

Are you currently fleeing? ❑ Yes ❑ No

Employment Status

Is client employed?

❑ Yes ❑ No

If yes:
Hours per week? _____
Where? _____

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

Income received from any source in the last 30 days

Earned Income	$	SSDI	$	TANF	$
Unemployment Insurance	$	SSI	$	GA	$
Workers Compensation	$	Retirement Income from Social Security	$	Alimony Spousal Support	$
Private Disability Insurance	$	VA Non-Service Connected Disability	$	Child Support	$
VA Service-Connected Disability	$	Pension or Retirement from a Former Job	$	Other (Specify):	$

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?	If no, reason?*		Currently Covered?	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 Health Administration (VHA)	Yes / No	_____	Indian Health Services Program	Yes / No	_____
Employer-provided Health Insurance	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.)

Housing Placement or New Housing Situation

- ❑ Place not meant for habitation (vehicle, abandoned bldg., train station/airport, or anywhere outside)
- ❑ Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter
- ❑ Safe haven
- ❑ Foster care home or foster care group home
- ❑ Hospital or other residential non-psychiatric medical facility
- ❑ Jail, prison, or juvenile detention facility
- ❑ Long-term care facility or nursing home
- ❑ Psychiatric hospital or other psychiatric facility
- ❑ Substance abuse treatment facility or detox center
- ❑ Hotel or motel paid for without emergency shelter voucher
- ❑ Transitional housing for homeless persons (including homeless youth)
- ❑ Host home (non-crisis)
- ❑ 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)
- ❑ Owned by client, no ongoing housing subsidy
- ❑ Owned by client, with ongoing housing subsidy
- ❑ Residential project or halfway house with no homeless criteria
- ❑ Rental by client, without ongoing housing subsidy
- ❑ Rental by client, with ongoing housing subsidy
  - ❑ With GPD TIP housing subsidy
  - ❑ With VASH housing subsidy
  - ❑ With RRH or equivalent subsidy
  - ❑ With Housing Choice Voucher (HCV) (tenant or project based)
  - ❑ In a public housing unit
  - ❑ With other ongoing housing subsidy
  - ❑ Housing Stability Voucher
  - ❑ Family Unification Program Voucher (FUP)
  - ❑ Permanent Supportive Housing
- ❑ Other _____
- ❑ Client doesn't know
- ❑ Client prefers not to answer

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 _____

For HOPWA Programs Only

1. Receiving AIDS Drug Assistance Program (ADAP)?

❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer

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 prefers not to answer

3. Receiving Ryan White-funded Medical or Dental Assistance?

❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer

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 prefers not to answer

4. T-cell (CD4) count available?

❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer

If yes, T-Cell counts? (0-1500): _____

How was the data obtained?

❑ Medical Report ❑ Client Report ❑ Other

5. Viral load available?

❑ Available ❑ Not Available
❑ Undetectable ❑ Client prefers not to answer

If available, viral load? (0-99999) _____

How was the data obtained?

❑ Medical Report ❑ Client Report ❑ Other

6. Prescribed Anti-Retroviral?

❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer