

HMIS UPDATE Data Collection Form for Solano County VA SSVF Programs

General Instructions

This is the update form for VA SSVF programs in Solano County.

Updates should be made any time there is a change in the following data elements:

- Income
- Disability status
- Non-Cash Benefits
- Medical Insurance
- Housing Move-In Date
- Domestic Violence

All HUD funded projects must have an Annual Update for each program participant within 15 days of the participant's anniversary of their entry date. This update must be conducted regardless of whether the information has changed for the client since entry or the most recent update.

All HUD funded Rapid Re-Housing Projects must have a 30-day update for each program participant. This update must be conducted regardless of whether the information has changed for the client since entry or the most recent update.

This form should be filled out for all household members and entered into HMIS accordingly.

Income and benefits collected by minor children in the household should be reported under the head of household.

No question should remain blank at the end of the assessment. The administrator of this intake must ask all questions of the client and mark the appropriate response.

Please note, current HMIS policies require that all data be entered into HMIS within three days of acquisition.

If you are confused about how to answer a question, please refer to the HMIS Data Dictionary which is contained in the resources folder for HMIS accessible through ServicePoint.

If the data dictionary does not answer your question, please reach out to solanoHMIS@homebaseccc.org for assistance.

CLIENT NAME:

DATE ADMINISTERED:

CLIENT STATUS

CLIENT LOCATION: CA-518

The only option for client location in HMIS is CA-518, which corresponds with the Solano Continuum of Care.

HOUSING MOVE-IN DATE

This field asks when the client is actually in housing. It is possible for a client to enter a project prior to actually taking possession of the unit. This is common when the project is providing housing locator services for the client. Provide the date the client actually takes possession of the unit. If the client has not taken possession of the unit at the time of project entry leave this field blank and provide an update at a later time when the unit becomes available.

		/			/				
Month		Day		Year					

DISABILITIES

Disability elements for HMIS data collections are based on client report. A client is not required to show proof of disability in order to respond “yes” to this question. Programs which require a disability for a client to be eligible for services may further investigate this element.

PHYSICAL DISABILITY

Does the client currently have a physical disability?

☐ Yes

☐ No

☐ Client doesn't know

☐ Client refused



[IF YES] Is the physical disability expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

☐ Yes

☐ No

☐ Client doesn't know

☐ Client refused

DEVELOPMENTAL DISABILITY

Does the client currently have a developmental disability?

☐ Yes

☐ No

☐ Client doesn't know

☐ Client refused



[IF YES] Is the developmental disability expected to substantially impair the client's ability to live independently?

☐ Yes

☐ No

☐ Client doesn't know

☐ Client refused

CHRONIC HEALTH CONDITION

Does the client currently have a chronic health condition?

☐ Yes

☐ No

☐ Client doesn't know

☐ Client refused



[IF YES] Is the chronic health condition expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

☐ Yes

☐ No

☐ Client doesn't know

☐ Client refused

HIV/AIDS

Does the client currently have HIV/AIDS?

☐ Yes

☐ No

☐ Client doesn't know

☐ Client refused



[IF YES] Is HIV/AIDS expected to substantially impair the client's ability to live independently?

☐ Yes

☐ No

☐ Client doesn't know

☐ Client refused

DISABILITIES (Cont.)

MENTAL HEALTH PROBLEM

Does the client currently have a mental health problem?

☐ Yes

☐ No

☐ Client doesn't know

☐ Client refused



[IF YES] Is the mental health problem expected to be of long-continued and indefinite duration and substantially impairs the client's ability to live independently?

☐ Yes

☐ No

☐ Client doesn't know

☐ Client refused

SUBSTANCE ABUSE PROBLEM

Does the client currently have a substance abuse problem?

☐ No

☐ Alcohol abuse

☐ Drug abuse

☐ Both alcohol and drug abuse

☐ Client doesn't know

☐ Client refused



[IF YES for alcohol abuse, drug abuse, or both alcohol and drug abuse] Is the substance abuse problem expected to be of long-continued and indefinite duration and substantially impairs client's ability to live independently?

☐ Yes

☐ No

☐ Client doesn't know

☐ Client refused

DISABLING CONDITION

Does the client currently have a disabling condition?

A disabling condition is any of the above-indicated disabilities (physical disability, developmental disability, chronic health condition, HIV/AIDS, mental health problem, or substance abuse problem) or any other physical, mental, or emotional impairment (including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury) that is expected to be of long-continued and indefinite duration and substantially impairs ability to live independently.

☐ Yes

☐ No

☐ Client doesn't know

☐ Client refused

INCOME AND BENEFITS

INCOME AND SOURCES

Only record regular, recurrent sources that are current as of today (i.e. not terminated). Income received for a minor member of the household (e.g. SSI) should be recorded under the Head of Household's information (income from employment of a minor can be excluded from the household income).

Does the client have any income from any source?

☐ Yes

☐ No



☐ Client doesn't know

☐ Client refused

INCOME AND BENEFITS (Cont.)

[IF YES] Answer Yes or No for each income source.

If the response for a source is 'Yes', enter the monthly amount received based on current income. If unsure of the exact monthly amount, enter client's best estimate. Answer 'No' for sources that have been terminated, even if they were received in the past.

Source of income	Receiving income from source?	If yes, monthly amount from source (round to nearest dollar)			
Earned income (i.e., employment income)	Yes <input type="checkbox"/>				
	No <input type="checkbox"/>	\$. 0 0
Unemployment Insurance	Yes <input type="checkbox"/>				
	No <input type="checkbox"/>	\$. 0 0
Supplemental Security Income (SSI)	Yes <input type="checkbox"/>				
	No <input type="checkbox"/>	\$. 0 0
Social Security Disability Insurance (SSDI)	Yes <input type="checkbox"/>				
	No <input type="checkbox"/>	\$. 0 0
VA Service-Connected Disability Compensation	Yes <input type="checkbox"/>				
	No <input type="checkbox"/>	\$. 0 0
VA Non-Service-Connected Disability Pension	Yes <input type="checkbox"/>				
	No <input type="checkbox"/>	\$. 0 0
Private disability insurance	Yes <input type="checkbox"/>				
	No <input type="checkbox"/>	\$. 0 0
Worker's Compensation	Yes <input type="checkbox"/>				
	No <input type="checkbox"/>	\$. 0 0
Temporary Assistance for Needy Families (TANF)	Yes <input type="checkbox"/>				
	No <input type="checkbox"/>	\$. 0 0
General Assistance (GA)	Yes <input type="checkbox"/>				
	No <input type="checkbox"/>	\$. 0 0
Retirement Income from Social Security	Yes <input type="checkbox"/>				
	No <input type="checkbox"/>	\$. 0 0
Pension or retirement income from a former job	Yes <input type="checkbox"/>				
	No <input type="checkbox"/>	\$. 0 0
Child support	Yes <input type="checkbox"/>				
	No <input type="checkbox"/>	\$. 0 0
Alimony or other spousal support	Yes <input type="checkbox"/>				
	No <input type="checkbox"/>	\$. 0 0
Other source If yes, specify source: _____	Yes <input type="checkbox"/>				
	No <input type="checkbox"/>	\$. 0 0
Total monthly income from all sources		\$. 0 0

CONNECTION WITH SOAR

☐ Yes

☐ No

☐ Client doesn't know

☐ Client refused

INCOME AND BENEFITS (Cont.)

NON-CASH BENEFITS

Does the client have any non-cash benefits from any source?

Only record regular, recurrent sources that are current as of today (not terminated). If a non-cash benefit is only received by a minor member of the household, record under the Head of Household's information.

☐ Yes

☐ Client doesn't know

☐ No

☐ Client refused



[IF YES] Answer 'Yes' or 'No' for each non-cash benefit source.

Source of income	Receiving Benefits from source?	
Supplemental Nutrition Assistance Program (SNAP)	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
TANF Child Care services (or use local name)	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
TANF transportation services (or use local name)	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
Other TANF-Funded Services (or use local name)	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
Other source	Yes	<input type="checkbox"/>
If yes, specify source: _____	No	<input type="checkbox"/>

HEALTH INSURANCE

Is the client currently covered by health insurance?

☐ Yes

☐ Client doesn't know

☐ No

☐ Client refused



[IF YES] Answer 'Yes' or 'No' for each health insurance source.

Answer 'No' for sources that have been terminated, even if they were received in the past.

No	Yes	Source
<input type="checkbox"/>	<input type="checkbox"/>	Medicaid
<input type="checkbox"/>	<input type="checkbox"/>	Medicare
<input type="checkbox"/>	<input type="checkbox"/>	State Children's Health Insurance Program (or use local name)
<input type="checkbox"/>	<input type="checkbox"/>	Veteran's Administration (VA) Medical Services
<input type="checkbox"/>	<input type="checkbox"/>	Employer-Provided Health Insurance
<input type="checkbox"/>	<input type="checkbox"/>	Health insurance obtained through COBRA
<input type="checkbox"/>	<input type="checkbox"/>	Private Pay Health Insurance
<input type="checkbox"/>	<input type="checkbox"/>	State Health Insurance for Adults (or use local name)
<input type="checkbox"/>	<input type="checkbox"/>	Indian Health Services Program
<input type="checkbox"/>	<input type="checkbox"/>	Other If Yes, specify source: _____

DOMESTIC VIOLENCE EXPERIENCE

DOMESTIC VIOLENCE

Is client a domestic violence victim/survivor?

☐ Yes

☐ No



☐ Client doesn't know

☐ Client refused

[IF YES] When did the experience occur?

☐ Within the past three months

☐ Three to six months ago (excluding six months exactly)

☐ Six months to one year ago (excluding one year exactly)

☐ One year ago or more

☐ Client doesn't know

☐ Client refused

[IF YES] Is the client currently fleeing?

☐ Yes

☐ No

☐ Client doesn't know

☐ Client refused

[IF YES] Caller ZIP: _____