HMIS UPDATE Data Collection Form for Solano County HMIS Projects

General Instructions

This is the update form for ALL projects in Solano County except for SSVF funded programs.

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

- Current Living Situation
- Housing Move-In Date
- Disability Status
- Income
- Non-Cash Benefits
- Health Insurance
- 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:

CURRENT LIVING SITUATION

START DATE 1

		/			/				
Month			Day			Year			

END DATE 1

		/			/				
Month			Day			Year			

INFORMATION DATE

		/			/				
Month			Day			Year			

What is the client's current living situation?

☐	Place not meant for habitation	☐	Rental by client, with GPD TIP housing subsidy
☐	Emergency shelter, including hotel or motel paid for with emergency shelter voucher or RHY-funded Host Home shelter	☐	Rental by client, with VASH housing subsidy
☐	Safe Haven	☐	Permanent housing (other than RRH) for formerly homeless persons
☐	Foster care home or foster care group home	☐	Rental by client, with RRH of equivalent subsidy
☐	Hospital or other residential non-psychiatric medical facility	☐	Rental by client, with HCV voucher (tenant or project based)
☐	Jail, prison, or juvenile detention facility	☐	Rental by client in a public housing unit
☐	Long-term care facility or nursing home	☐	Rental by client, no ongoing housing subsidy
☐	Psychiatric hospital or other psychiatric facility	☐	Rental by client, with other ongoing housing subsidy
☐	Substance abuse treatment facility or detox center	☐	Owned by client, with ongoing housing subsidy
☐	Residential project or halfway house with no homeless criteria	☐	Owned by client, no ongoing housing subsidy
☐	Hotel or motel paid for without emergency shelter voucher	☐	Other
☐	Transitional housing for homeless persons (including homeless youth)	☐	Worker unable to determine
☐	Host Home (non-crisis)	☐	Client doesn't know
☐	Staying or living in a friend's room, apartment or house	☐	Client refused
☐	Staying or living in a family member's room, apartment or house		

IF OTHER, SPECIFY: _____

PROVIDER THAT VERIFIED LIVING SITUATION: _____

CURRENT LIVING SITUATION

Is the client going to have to leave their current living situation within 14 days?

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

[IF YES] *Has a subsequent residence been identified?*

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

Does the client have resources or support networks to obtain other permanent housing?

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

Has the client had a lease or ownership interest in a permanent housing unit in the last 60 days?

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

Has the client moved two or more times in the last 60 days?

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

LOCATION DETAILS: _____

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.

		/			/				
Month			Day			Year			

DISABILITY STATUS

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	☐	Client doesn't know
☐	No	☐	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	☐	Client doesn't know
☐	No	☐	Client refused

DEVELOPMENTAL DISABILITY

Does the client currently have a developmental disability?

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

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

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

CHRONIC HEALTH CONDITION

Does the client currently have a chronic health condition?

☐	Yes	☐	Client doesn't know
☐	No	☐	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	☐	Client doesn't know
☐	No	☐	Client refused

HIV/AIDS

Does the client currently have HIV/AIDS?

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

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

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

MENTAL HEALTH PROBLEM

Does the client currently have a mental health problem?

☐	Yes	☐	Client doesn't know
☐	No	☐	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	☐	Client doesn't know
☐	No	☐	Client refused

SUBSTANCE ABUSE PROBLEM

Does the client currently have a substance abuse problem?

☐	No	☐	Client doesn't know
☐	Alcohol abuse	☐	Client refused
☐	Drug abuse		
☐	Both alcohol and drug abuse		

↓

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

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

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. ***Does the client currently have a disabling condition?***

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

INCOME AND BENEFITS

INCOME AND SOURCES

Record regular, recurrent sources that are current (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). If the client has income, enter the monthly amount received. Answer 'No' for sources that have been terminated, even if they were received in the past.

Does the client have any income from any source?

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

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

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

INCOME AND BENEFITS (CONT.)

What is the client's income as a percentage of AMI?

☐	Less than 30%
☐	30% – 50%
☐	Greater than 50%

Does the client have a connection with SOAR?

☐	Yes
☐	No
☐	Client doesn't know
☐	Client refused

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

Yes	No	Source of income
☐	☐	Supplemental Nutrition Assistance Program (SNAP)
☐	☐	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
☐	☐	TANF Child Care services
☐	☐	TANF transportation services
☐	☐	Other TANF-Funded Services
☐	☐	Other: _____

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.*

Yes	No	Source
☐	☐	Medicaid
☐	☐	Medicare
☐	☐	State Children's Health Insurance Program (or use local name)
☐	☐	Veteran's Administration (VA) Medical Services
☐	☐	Employer-Provided Health Insurance
☐	☐	Health insurance obtained through COBRA
☐	☐	Private Pay Health Insurance
☐	☐	State Health Insurance for Adults (or use local name)
☐	☐	Indian Health Services Program
☐	☐	Other: _____

EMPLOYMENT

Is the client employed?

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

If YES, what is the type of employment?

☐	Full-time	☐	Client doesn't know
☐	Part-time	☐	Client refused
☐	Seasonal/sporadic (including day labor)		

If NO, why is the client not employed?

☐	Looking for work	☐	Client doesn't know
☐	Unable to work	☐	Client refused
☐	Not looking for work		

DOMESTIC VIOLENCE EXPERIENCE

Is client a domestic violence victim or survivor?

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

If YES, when did the experience occur?

☐	Within the past three months	☐	One year ago or more
☐	Three to six months ago (excluding six months exactly)	☐	Client doesn't know
☐	Six months to one year ago (excluding one year exactly)	☐	Client refused

If YES, is the client currently fleeing?

☐	Yes	☐	Client doesn't know
☐	No	☐	Client refused

If YES, caller ZIP Code: _____

CLIENT'S RESIDENCE OR LAST PERMANENT ADDRESS

Address _____ *Apt / Unit* _____

City _____ *State* _____ *ZIP Code* _____

County _____

Phone number _____ *Email address* _____

What is the data quality of the client's residence or last permanent address?

☐	Full address reported	☐	Client doesn't know
☐	Incomplete or estimated address reported	☐	Client refused

EMERGENCY CONTACT

Name _____

Address _____ *Apt / Unit* _____

City _____ *State* _____ *ZIP Code* _____

Phone number _____ *Email address* _____

LANDLORD CONTACT

Name _____

Address _____ *Apt / Unit* _____

City _____ *State* _____ *ZIP Code* _____

Phone number _____ *Email address* _____

EMPLOYER CONTACT

Name _____

Address _____ *Apt / Unit* _____

City _____ *State* _____ *ZIP Code* _____

Phone number _____ *Email address* _____