

HMIS UPDATE Data Collection Form for Solano County RHY Programs

General Instructions

This is the update form for RHY programs in Solano County. This form should be filled out for all household members and entered into HMIS accordingly.

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 30 days of the anniversary of the head of household's 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.

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. 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

		/			/				
Month			Day			Year			

END DATE

		/			/				
Month			Day			Year			

INFORMATION DATE

		/			/				
Month			Day			Year			

CURRENT LIVING SITUATION

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

If **OTHER**, specify: _____

CURRENT LIVING SITUATION (CONTINUED)

PROVIDER VERIFYING LIVING SITUATION

<input type="checkbox"/>	BayNorth Church of Christ	<input type="checkbox"/>	Mission Samoa
<input type="checkbox"/>	Berkeley Food & Housing Project	<input type="checkbox"/>	Nation's Finest
<input type="checkbox"/>	Caminar, Inc.	<input type="checkbox"/>	Northern California Family Center
<input type="checkbox"/>	Catholic Charities of Yolo-Solano	<input type="checkbox"/>	On the Move
<input type="checkbox"/>	City of Fairfield Homeless Outreach	<input type="checkbox"/>	Resource Connect Solano
<input type="checkbox"/>	City Vallejo Housing Authority	<input type="checkbox"/>	SHELTER, Inc.
<input type="checkbox"/>	Community Action North Bay	<input type="checkbox"/>	Solano County Healthy & Social Services
<input type="checkbox"/>	Edge Community Church	<input type="checkbox"/>	VA of Northern California
<input type="checkbox"/>	Fighting Back Partnership	<input type="checkbox"/>	Vacaville Solano Services
<input type="checkbox"/>	Lutheran Social Services	<input type="checkbox"/>	Volunteers of America

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

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
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If YES, please specify.	Yes	No	Client doesn't know	Client refused
Has a subsequent residence been identified?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the client have resources or support networks to obtain other permanent housing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the client had a lease or ownership interest in a permanent housing unit in the last 60 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the client moved two or more times in the last 60 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

LOCATION DETAILS: _____

DATE OF ENGAGEMENT

This field asks when the client was first engaged by the project.

		/			/				
Month			Day			Year			

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			

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.

SUBSTANCE ABUSE

<input type="checkbox"/>	Yes: Alcohol abuse only	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes: Drug abuse only	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Yes: Alcohol and drug abuse	<input type="checkbox"/>	Client refused



If YES for **alcohol abuse**, **drug abuse**, or **both alcohol and drug abuse**, is the disability expected to be of long-continued and indefinite duration and substantially impairs client's ability to live independently?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused

IF YES, DISABILITY START DATE

		/			/			
Month			Day			Year		

NOTE ON DISABILITY

CHRONIC HEALTH CONDITION

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know



If YES for **chronic health condition**, is the disability expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused

IF YES, DISABILITY START DATE

		/			/			
Month			Day			Year		

NOTE ON DISABILITY

DEVELOPMENTAL

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know



If YES for **developmental disability**, is the disability expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused

IF YES, DISABILITY START DATE

		/			/			
Month			Day			Year		

NOTE ON DISABILITY

DISABILITIES (CONTINUED)

HIV/AIDS

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know



If **YES** for **HIV/AIDS**, is the disability expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused

IF YES, DISABILITY START DATE

		/			/			
Month			Day			Year		

NOTE ON DISABILITY

MENTAL HEALTH PROBLEM

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know



If **YES** for **mental health problem**, is the disability expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused

IF YES, DISABILITY START DATE

		/			/			
Month			Day			Year		

NOTE ON DISABILITY

PHYSICAL DISABILITY

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know



If **YES** for **physical disability**, is the disability expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused

IF YES, DISABILITY START DATE

		/			/			
Month			Day			Year		

NOTE ON DISABILITY

DISABLING CONDITION

A disabling condition is any of the above-indicated disabilities 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 impair ability to live independently. **Does the client currently have a disabling condition?**

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Client refused

INCOME

Record regular, recurrent sources that are current (i.e. not terminated). Income received for a minor member of the household should be recorded under the Head of Household's information. 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?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
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If YES, answer 'Yes' or 'No' for each income source.

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

What is the client's income as a percentage of Area Median Income (AMI)?

<input type="checkbox"/> < 30%	<input type="checkbox"/> 30–50%	<input type="checkbox"/> > 50%
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Does the client have a connection with SSI/SSDI, Outreach, Access, and Recovery (SOAR)?

<input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> No	<input type="checkbox"/> Client refused

NON-CASH BENEFITS

Only record regular, recurrent sources that are current (i.e. not terminated). Non-cash benefits received for a minor member of the household should be recorded under the Head of Household's information. Answer 'No' for sources that have been terminated, even if they were received in the past.

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

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
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If YES, answer 'Yes' or 'No' for each non-cash benefit source.

Source of Non-Cash Benefit	Receiving source?		If YES, date client began receiving source	If YES, monthly amount from source (round to nearest dollar)								
Supplemental Nutrition Assistance Program, (i.e. CalFresh or Food Stamps)	Yes	<input type="checkbox"/>		\$.	0	0
	No	<input type="checkbox"/>										
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	Yes	<input type="checkbox"/>		\$.	0	0
	No	<input type="checkbox"/>										
TANF Child Care services	Yes	<input type="checkbox"/>		\$.	0	0
	No	<input type="checkbox"/>										
TANF Transportation Services	Yes	<input type="checkbox"/>		\$.	0	0
	No	<input type="checkbox"/>										
Other TANF-Funded Services	Yes	<input type="checkbox"/>		\$.	0	0
	No	<input type="checkbox"/>										
Other: _____	Yes	<input type="checkbox"/>		\$.	0	0
	No	<input type="checkbox"/>										

HEALTH INSURANCE

Only record regular, recurrent sources that are current (i.e. not terminated). Answer 'No' for sources that have been terminated, even if they were received in the past.

Is the client currently covered by health insurance?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
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If YES, answer 'Yes' or 'No' for each health insurance source.

Source of Health Insurance	Receiving health insurance source?		If YES, date client began receiving source	For HOPWA, specify private pay insurance source, if applicable	For HOPWA, specify reason not covered, if applicable
Medicaid (i.e. Medi-Cal)	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
Medicare	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
State Children's Health Insurance Program (CHIP)	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
Veteran's Administration (VA) Medical Services	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
Employer-Provided Health Insurance	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
Health insurance obtained through COBRA	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
Private Pay Health Insurance	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
State Health Insurance for Adults	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
Indian Health Services Program	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
Other: _____	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			

EMPLOYMENT

Is the client employed?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
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If **YES**, specify the type of employment.

<input type="checkbox"/> Full-time	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Part-time	<input type="checkbox"/> Client refused
<input type="checkbox"/> Seasonal/sporadic (including day labor)	

If **NO**, specify the reason the client is not employed.

<input type="checkbox"/> Looking for work	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Unable to work	<input type="checkbox"/> Client refused
<input type="checkbox"/> Not looking for work	

DOMESTIC VIOLENCE

Is the client a domestic violence victim or survivor?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
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If **YES**, when did the experience occur?

<input type="checkbox"/> Within the past three months	<input type="checkbox"/> One year ago or more
<input type="checkbox"/> Three to six months ago (excluding six months exactly)	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Six months to one year ago (excluding one year exactly)	<input type="checkbox"/> Client refused

If **YES**, is the client currently fleeing?

<input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> No	<input type="checkbox"/> Client refused

RHY CLIENT STATUS

Is the client pregnant?

<input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> No	<input type="checkbox"/> Client refused

If **YES**, provide the projected birth date.

		/			/				
Month			Day			Year			

CONTACT INFORMATION

Address _____ Apt/Unit _____

City _____ State _____ ZIP Code _____ County _____

County _____

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

<input type="checkbox"/> Full address reported	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Incomplete or estimated address reported	<input type="checkbox"/> Client refused

Phone number _____ Email address _____

START DATE

		/			/				
Month		Day		Year					

END DATE (if applicable)

		/			/				
Month		Day		Year					

Landlord's Name _____ Landlord's Address _____

Landlord's City _____ Landlord's State _____ Landlord's Phone _____

EMERGENCY CONTACT

Contact's Name _____ Contact's Address _____

Contact's City _____ Contact's State _____ Landlord Phone _____

Second Phone Number _____ Relationship to Client _____

START DATE

		/			/				
Month		Day		Year					

END DATE (if applicable)

		/			/				
Month		Day		Year					