Homeless Resource Council of the Sierras — HMIS Update Form

Update Summary

Project Update Date: ________/__________/________ **Intake Staff Name:** ______________________________

Project Name: ______________________________ **HMIS Client ID** (Must have an ID)**:** ____________________

Basic Client Profile (Universal Data Elements)

Name (First, Middle, Last)	______________________________	**Date of Birth**	_________/_________/_________

Detailed Client Information (Program-Level Data Elements)

Income Received from Any Source	☐Yes ☐Client Doesn't Know ☐No ☐Client Refused	**Non-Cash Benefits Received**	☐Yes ☐Client Doesn't Know ☐No ☐Client Refused

If yes, indicate all sources and dollar amounts for applicable sources

Source of Income	Receiving?	Amount
Earned Income	☐Yes	$.
	☐No	
Unemployment Insurance	☐Yes	$.
	☐No	
Supplemental Security Income (SSI)	☐Yes	$.
	☐No	
Social Security Disability Insurance (SSDI)	☐Yes	$.
	☐No	
VA Service – Connected Disability Compensation	☐Yes	$.
	☐No	
VA Non-Service Connected Disability Pension	☐Yes	$.
	☐No	
Private Disability Insurance	☐Yes	$.
	☐No	
Workers' Compensation	☐Yes	$.
	☐No	
Temporary Assistance for Needy Families (TANF)	☐Yes	$.
	☐No	
General Assistance (GA)	☐Yes	$.
	☐No	
Retirement Income from Social Security	☐Yes	$.
	☐No	
Pension/Retirement from a former job	☐Yes	$.
	☐No	
Child Support	☐Yes	$.
	☐No	
Alimony/Spousal Support	☐Yes	$.
	☐No	
Other: ____________________	☐Yes	$.
	☐No	
Total *Monthly* Income		$.

If yes, indicate all sources that apply

Source of Non-Cash Benefit	Yes	No
Supplemental Nutritional Assistance Program (SNAP) (CalFresh or "Food Stamps")	☐	☐
Special Supplementation Nutritional Program for (WIC)	☐	☐
TANF Child Care Services	☐	☐
TANF Transportation Services	☐	☐
Other TANF-Funded Services	☐	☐
Other:____________________________	☐	☐

Covered by Health Insurance	☐Yes ☐Client Doesn't Know ☐No ☐Client Refused

If yes, indicate all sources that apply

Source of Insurance	Yes	No
MEDICAID (Medi-Cal)	☐	☐
MEDICARE	☐	☐
State Children Health Insurance Program	☐	☐
VA Medical Services	☐	☐
Employer Provided Health Insurance	☐	☐
Health Insurance obtained through COBRA	☐	☐
Private Pay Health Insurance	☐	☐
State Health Insurance for Adults	☐	☐
Indian Health Services Program	☐	☐
Other: ____________________________	☐	☐

Physical Disability	☐Yes ☐Client Doesn't Know ☐No ☐Client Refused	**Developmental Disability**	☐Yes ☐Client Doesn't Know ☐No ☐Client Refused
If Yes, expected to be of long-continued/indefinite duration; substantially impairs ability to live independently.	☐Yes ☐Client Doesn't Know ☐No ☐Client Refused	*If Yes, expected to be of long-continued/indefinite duration; substantially impairs ability to live independently.*	☐Yes ☐Client Doesn't Know ☐No ☐Client Refused
Chronic Health Condition	☐Yes ☐Client Doesn't Know ☐No ☐Client Refused	**HIV/AIDS**	☐Yes ☐Client Doesn't Know ☐No ☐Client Refused
If Yes, expected to be of long-continued/indefinite duration; substantially impairs ability to live independently.	☐Yes ☐Client Doesn't Know ☐No ☐Client Refused	*If Yes, expected to substantially impairs ability to live independently.*	☐Yes ☐Client Doesn't Know ☐No ☐Client Refused
Mental Health Problem	☐Yes ☐Client Doesn't Know ☐No ☐Client Refused	**Substance Abuse Problem**	☐Alcohol Abuse ☐Drug Abuse ☐Both Alcohol & Drug Abuse ☐No ☐Client Doesn't Know ☐Client Refused
If Yes, expected to be of long-continued/indefinite duration; substantially impairs ability to live independently.	☐Yes ☐Client Doesn't Know ☐No ☐Client Refused	*If Yes, expected to be of long-continued/indefinite duration; substantially impairs ability to live independently.*	☐Yes ☐Client Doesn't Know ☐No ☐Client Refused

Domestic Violence Victim/Survivor	☐Yes ☐No ☐Client Doesn't Know ☐Client Refused	*If Yes, when experience occurred?*	☐Within past three months ☐Client Doesn't Know ☐Three to six months ago ☐Client Refused ☐Six to twelve months ago ☐More than a year ago
		If yes, are you currently fleeing?	☐Yes ☐Client Doesn't Know ☐No ☐Client Refused

Client Locations	**CA-515**

Street Outreach/Night by Night Shelter Stays/PATH Street Outreach Only			
Contact Date	___________/___________/___________	**Staying on Streets, in ES, or SH**	☐Yes ☐No ☐Worker unable to determine
Date of Engagement	___________/___________/___________		

Permanent Housing Projects Only (RRH and PSH Only)		
Housing Move-In Date	___________/___________/___________	

PATH Projects Only			
PATH Status			
Client became enrolled in PATH	☐Yes ☐No	*IF no, reason not enrolled*	☐Client was found ineligible for PATH ☐Client was not enrolled for other reason(s)
Date of Determination		___________/___________/___________	

Connection with SOAR	☐Yes	☐No