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HMIS #:  
CM Name:  
Project Entry Date:

**Santa Barbara County HMIS -Standard Update**

This form is designed to be completed by a service provider while interviewing a client.

A separate Standardized Update form should be completed for each member of the household.

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| **Client Profile** | | |
| **First Name** |  | **Middle** |
| **Last Name** |  | |

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| |  |  | | --- | --- | | Housing Move-in Date |  |   **Monthly Income – Cash Benefits** | |
| **Income from any source?** | Yes No Client doesn’t know Client refused |
| **Total monthly income:** | $ |
|  Alimony or Other Spousal Income $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   Child Support $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   Earned Income $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   General Assistance $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   Other $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  If Other specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Pension or retirement from another job $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   Private disability insurance $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  Retirement income from Social Security $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   SSDI $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   SSI $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   TANF $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   Unemployment Insurance $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   VA Non-service connect disability pension $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   VA Service connected disability compensation $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   Worker’s compensation $  **Date start receiving:\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **Non-Cash Benefits** | |
| **Income from any source?** | Yes No Client doesn’t know Client refused |
|  Special supplement nutrition program for WIC $   Supplemental nutrition assistance program  (Food Stamps) $   TANF-Child care services $ |  TANF Transportation services $   Other TANF funded services $   Other Source $  If Other, specify: |

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| **Health Insurance** | |
| **Covered by health insurance?** | Yes No Client doesn’t know Client refused |
|  Medicaid   Medicare   State children’s health insurance program   VA Medical Services   Employer provided |  Private pay health plan   State health insurance for adults   Indian health services program   Other Source  If Other, specify: |

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| **Disability** | | | | |
| **Does the client have a disabling condition?** | |  Yes   No |  Client Doesn’t Know   Client Refused | |
| **If Yes, please complete the following for each disability type** | | | | |
| **Alcohol Abuse** |  Yes  No  Client Doesn’t Know   Client Refused | Condition Long term? | |  Yes  No  Client Doesn’t Know  Client Refused |
| **Disability State Date** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | If Yes, expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? | |  Yes  No  Client Doesn’t Know  Client Refused |
| **Both Alcohol & Drug Abuse**  **Disability Start Date** |  Yes  No  Client Doesn’t Know   Client Refused  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Condition Long term? | |  Yes  No  Client Doesn’t Know  Client Refused |
| If Yes, expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? | |  Yes  No  Client Doesn’t Know  Client Refused |
| **Chronic Health Condition**  **Disability Start Date** |  Yes  No  Client Doesn’t Know   Client Refused  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Condition Long term? | |  Yes  No  Client Doesn’t Know  Client Refused |
| If Yes, expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? | |  Yes  No  Client Doesn’t Know  Client Refused |
| **Developmental** |  Yes  No  Client Doesn’t Know   Client Refused | Condition Long term? | |  Yes  No  Client Doesn’t Know  Client Refused |
| **Disability State Date** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | If Yes, expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? | |  Yes  No  Client Doesn’t Know  Client Refused |

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| **Disability** |  |  |  |
| **Drug Abuse** |  Yes  No  Client Doesn’t Know   Client Refused | Condition Long term? |  Yes  No  Client Doesn’t Know  Client Refused |
| **Disability State Date** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? |  Yes  No  Client Doesn’t Know  Client Refused |
| **HIV/AIDS** |  Yes  No  Client Doesn’t Know   Client Refused | Condition Long term? |  Yes  No  Client Doesn’t Know  Client Refused |
| **Disability State Date** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? |  Yes  No  Client Doesn’t Know  Client Refused |
| **Mental Health Problem** |  Yes  No  Client Doesn’t Know   Client Refused | Condition Long term? |  Yes  No  Client Doesn’t Know  Client Refused |
| **Disability State Date** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? |  Yes  No  Client Doesn’t Know  Client Refused |
| **Physical** |  Yes  No  Client Doesn’t Know   Client Refused | Condition Long term? |  Yes  No  Client Doesn’t Know  Client Refused |
| **Disability State Date** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? |  Yes  No  Client Doesn’t Know  Client Refused |

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| **Domestic Violence** | | |
| Domestic Violence Victim/Survivor  If yes, when did experience occur  If yes, are you currently fleeing? |  Yes   No |  Client Doesn’t Know   Client Refused |
|  Within past three months   Three months to less than six months ago (excluding six months exactly)   Six months to less than one year ago (excluding one year exactly)   One year or more ago   Client doesn’t know   Client refused | |
|  Yes   No |  Client Doesn’t Know   Client Refused |

*I (Adult client or Head of Household) certify that the information I have provided here is true/correct to the best of my knowledge*

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| Print Name of Client | Signature of Client | Date |
| Print Name of Intake Worker | Signature of Intake Worker | Date |