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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 SourceIf 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/SurvivorIf yes, when did experience occurIf 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 |