

HMIS #  
CM Name   
Project Entry Date / /

**Santa Cruz County HMIS - Standard Update**

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

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

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| **Client Profile** | | |
| **First Name** |  | **Middle** |
| **Last Name** |  |  |
| **Alias** (If multiple aliases, separate by commas) |  | |

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| **Disabling Conditions and Barriers** | | |
| **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?  If Yes, If the problem is expected to be of long-continued and indefinite duration and substantially impedes a client’s ability to live independently. |  Yes  No  Client Doesn’t Know  Client Refused |
| **Drug Abuse**  Yes  No  Client Doesn’t Know  Client Refused | Condition Long Term?  If Yes, If the problem is expected to be of long-continued and indefinite duration and substantially impedes a client’s ability to live independently. |  Yes  No  Client Doesn’t Know  Client Refused |
| **Both Alcohol & Drug Abuse**  Yes  No  Client Doesn’t Know  Client Refused | Condition Long Term?  If Yes, If the problem is expected to be of long-continued and indefinite duration and substantially impedes a client’s ability to live independently. |  Yes  No  Client Doesn’t Know  Client Refused |
| **Chronic Health Condition**  Yes  No  Client Doesn’t Know  Client Refused | Condition Long Term?  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 Disability**  Yes  No  Client Doesn’t Know  Client Refused | Substantially Impairs Independence?  If Yes, Expected to substantially impair ability to live independently. |  Yes  No  Client Doesn’t Know  Client Refused |

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| **Disabling Conditions and Barriers** | | |
| **Physical Disability**  Yes  No  Client Doesn’t Know  Client Refused | Condition Long Term?  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 | If Yes, Substantially Impairs Independence?  Expected to substantially impair 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?  If Yes, if the problem is expected to be of long-continued and indefinite duration and substantially impedes a client’s ability to live independently. |  Yes  No  Client Doesn’t Know  Client Refused |
| **Domestic Violence Victim/Survivor**  Yes  No  Client Doesn’t Know  Client Refused | Last Occurrence?  If Yes, How long ago did the person have the most recent experience? |  Within the past three months   Three to six months ago (excluding six months exactly)  Six months to one year ago (excluding one year exactly)  One year ago or more  Client Doesn’t Know  Client Refused |
| **Are You Currently Fleeing?** | Are you currently fleeing domestic violence? |  Yes  No  Client Doesn’t Know  Client Refused |

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| **Monthly Income – Cash Benefits** | |
| **Income from any source?** | Yes No Client doesn’t know Client refused |
|  Earned Income $   Unemployment Insurance  $   Worker’s Compensation  $   Private Disability Insurance  $   VA Service-Connected Disability Pension $   Social Security Disability Insurance SSDI $ |  Supplemental Security Income SSI $   Retirement income from Social Security $   VA Non-service connect disability pension $   Pension or Retirement Income from a Former Job $   Temporary Assistance for Needy Families TANF $   General Assistance (GA) $   Alimony and Other Spousal Support $   Child Support $   Other Cash Income $  If Other Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Total Cash Income for Individual** | **TOTAL**: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Non-Cash Benefits** | |
| **Receiving Non-Cash Benefits?** | Yes No Client doesn’t know Client refused |
|  Supplemental Nutrition Assistance Program (SNAP)   Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)   TANF Childcare Services |  TANF Transportation Services   Other TANF-Funded Services   Other Non-Cash Benefit  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   Veteran’s Administration (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 Health Insurance  If Other Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Employment Status** | | |
| **Employed** |  Yes   No |  Client Doesn’t Know   Client Refused |
| **If Yes, Type of Employment** |  Full-time   Part-time   Seasonal/Sporadic (including day labor) | |
| **If No, Why Not Employed** |  Looking for work   Unable to work   Not looking for work |  |

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| **Last Grade Completed** | | |
| **Last Grade Completed** |  Less than Grade 5 Grades 5-6 Grades 7-8 Grades 9-11 Grade 12/ High school diploma School program does not have grade levels | GED Some college Associate’s degree Bachelor’s degree Graduate degree Vocational certification  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 |