

HMIS #  
CM Name   
Project Entry Date / /

**Santa Cruz County HMIS - Standard Update/Annual 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.

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

|  |  |  |
| --- | --- | --- |
| **Disabling Conditions and Barriers** | | |
| **Physical Disability**  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 |
| **Developmental Disability** |  Yes  No  Client Doesn’t Know  Client Refused | |
| **Chronic Health Condition**  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 |
| **HIV - AIDS** |  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 |
| **Substance Abuse Problem**  No   Alcohol Abuse  Drug Abuse  Both Alcohol & Drug Abuse  Client Doesn’t Know  Client Refused | Condition Long Term?  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** | | |
| **Domestic Violence Victim/Survivor**  Yes  No  Client Doesn’t Know  Client Refused | Last Occurrence  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?** |  Yes  No  Client Doesn’t Know  Client Refused |  |

|  |  |
| --- | --- |
| **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**: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |  |
| --- | --- | --- | --- |
| **Contact Information** [Optional – can be entered in Location/Contact Tab] | | | |
| **Phone Number** |  | | |
| **Email** |  | | |
| **Current Address (if applicable)** |  | | |
| **City** |  | | |
| **State** |  |  | **Zip Code** |

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

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