

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.

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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** |
| **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 |

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| **Domestic Violence** |
| **Domestic Violence Victim/Survivor** Yes  No Client Doesn’t Know Client Refused | Last OccurrenceHow 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 |  |

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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 InsuranceSSDI $  |  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 BenefitIf 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 InsuranceIf Other Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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| **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.

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