

Merced City & County CoC HMIS - Standard UPDATE

This form is designed to be completed by a service provider while interviewing a client.
A separate Standard Update should be completed for each member of the household.

HMIS # _____

CM Name: _____

Project Entry Date: ____/____/____

Household Information

Is the client: Single Adult Adult in Household ****If Single Adult is checked go to Client Profile****

If Adult in Household is checked: Are you the Head of Household (HoH)? Yes No

If No, Name of HoH: _____

How many adults in the household? _____ How many children in household? _____

If you are in a household, what is your relationship to the HoH?

Self (head of household) | Head of household's child | Head of household's spouse or partner

Other: relation to head of household | Other: non-relation member

Client Profile

First Name: _____ Middle Name: _____ Last Name: _____

Social Security Number: ____/____/____ **May collect last 4 numbers instead of all 9 numbers**

U.S Military Veteran?

Yes | No | Client doesn't know | Client prefers not to answer | Data not collected

Housing Move-In Date: ____/____/____

Monthly Income – Cash Benefits

Income from any source? If Yes, total monthly income: \$ _____

- Yes | No | Client doesn't know | Client prefers not to answer | Data not collected

Income source (check all that apply)	Income Source Amount	Date Started Receiving
<input type="checkbox"/> Alimony or other spousal income	\$ _____	_____/_____/_____
<input type="checkbox"/> Child Support	\$ _____	_____/_____/_____
<input type="checkbox"/> Earned Income	\$ _____	_____/_____/_____
<input type="checkbox"/> General Assistance	\$ _____	_____/_____/_____
<input type="checkbox"/> Other	\$ _____	_____/_____/_____
<input type="checkbox"/> Pension or retirement from another job	\$ _____	_____/_____/_____
<input type="checkbox"/> Private disability insurance	\$ _____	_____/_____/_____
<input type="checkbox"/> Retirement income from Social Security	\$ _____	_____/_____/_____
<input type="checkbox"/> SSDI	\$ _____	_____/_____/_____
<input type="checkbox"/> SSI	\$ _____	_____/_____/_____
<input type="checkbox"/> TANF	\$ _____	_____/_____/_____
<input type="checkbox"/> Unemployment Insurance	\$ _____	_____/_____/_____
<input type="checkbox"/> VA Non-Service connect disability pension	\$ _____	_____/_____/_____
<input type="checkbox"/> VA Service connected disability compensation	\$ _____	_____/_____/_____
<input type="checkbox"/> Worker's Compensation	\$ _____	_____/_____/_____

Non-Cash Benefits

Non-cash benefits from any source?

- Yes | No | Client doesn't know | Client prefers not to answer | Data not collected

Type of Benefit (check all that apply)	Income Source Amount	Date Started Receiving
<input type="checkbox"/> Supplemental nutrition assistance program	\$ _____	_____/_____/_____
<input type="checkbox"/> Special supplement nutrition program for WIC	\$ _____	_____/_____/_____
<input type="checkbox"/> TANF – Child care services	\$ _____	_____/_____/_____
<input type="checkbox"/> TANF – Transportation services	\$ _____	_____/_____/_____
<input type="checkbox"/> Other TANF funded services	\$ _____	_____/_____/_____
<input type="checkbox"/> Other Source	\$ _____	_____/_____/_____

If "Other Source", specify: _____

Health Insurance

Covered by Health Insurance?

Yes | No | Client doesn't know | Client prefers not to answer | Data not collected

Type of Health Insurance	State Date Receiving
<input type="checkbox"/> Employer provided health insurance	____/____/____
<input type="checkbox"/> Health insurance obtained through COBRA	____/____/____
<input type="checkbox"/> Indian Health Services program	____/____/____
<input type="checkbox"/> Medicare	____/____/____
<input type="checkbox"/> Medicaid	____/____/____
<input type="checkbox"/> Private pay health plan	____/____/____
<input type="checkbox"/> State children's health insurance program	____/____/____
<input type="checkbox"/> State health insurance for adults	____/____/____
<input type="checkbox"/> VA Health Administration (VHA)	____/____/____
<input type="checkbox"/> Other Source	____/____/____

If "Other Source", specify: _____

Disability

Does the client have a disabling condition?

Yes | No | Client doesn't know | Client prefers not to answer | Data not collected

Disability Type/Determination	Condition Long Term?	Disability Start Date
<p style="text-align: center;">Alcohol Use Disorder</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	____/____/____
<p style="text-align: center;">Both Alcohol & Drug Use Disorder</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	____/____/____
<p style="text-align: center;">Chronic Health Condition</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	____/____/____
<p style="text-align: center;">Developmental</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	____/____/____
<p style="text-align: center;">Substance Use Disorder</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	____/____/____
<p style="text-align: center;">HIV/AIDS</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	____/____/____
<p style="text-align: center;">Mental Health Disorder</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	____/____/____
<p style="text-align: center;">Physical</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	____/____/____

Domestic Violence

Domestic Violence Survivor?

Yes | No | Client doesn't know | Client prefers not to answer | Data not collected

If Yes, when did experience occur?

Within past 3 months | 3-6 months ago | One year or more | Client doesn't know
 Client prefers not to answer
 Data not collected

If Yes, are you currently fleeing?

Yes | No | Client doesn't know | Client prefers not to answer | Data not collected

Current Living Situation

Information date: _____/_____/_____

Homeless Situation

Place not meant for habitation (e.g., vehicle, abandoned building, bus/train/subway/airport or anywhere outside)
 Emergency shelter, including hotel or motel paid for with emergency shelter voucher, Host Home shelter
 Safe Haven

Institutional Setting

<input type="checkbox"/> Foster care home or foster care group home	<input type="checkbox"/> Long-term care facility or nursing home
<input type="checkbox"/> Hospital or other residential non-psychiatric medical facility	<input type="checkbox"/> Psychiatric hospital or other psychiatric facility
<input type="checkbox"/> Jail, Prison, or juvenile detention facility	<input type="checkbox"/> Substance abuse treatment facility or detox center

Temporary Housing Situation

<input type="checkbox"/> Transitional housing for homeless persons (incl youth)	<input type="checkbox"/> Staying or living with friends, temporary tenure
<input type="checkbox"/> Residential project or halfway house, no homeless criteria	<input type="checkbox"/> Moved from one HOPWA funded project to HOPWA TH
<input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher	<input type="checkbox"/> Staying/living in a friend's room, apartment, house
<input type="checkbox"/> Host Home (non-crisis)	<input type="checkbox"/> Staying/living in a family member's room apartment, house
<input type="checkbox"/> Staying or living with family, temporary tenure	

Permanent Housing Situation

<input type="checkbox"/> Staying or living with family, permanent tenure	<input type="checkbox"/> Rental by client, no ongoing housing subsidy
<input type="checkbox"/> Staying or living with friends, permanent tenure	<input type="checkbox"/> Rental by client, with ongoing housing subsidy*
<input type="checkbox"/> Moved from one HOPWA funded project to HOPWA PH	<input type="checkbox"/> Owned by client, with ongoing housing subsidy
	<input type="checkbox"/> Owned by client, no ongoing housing subsidy

*If rental by client, with on-going housing subsidy, specify subsidy:

<input type="checkbox"/> GDP TIP housing subsidy	<input type="checkbox"/> Rental by client, with other ongoing housing subsidy
<input type="checkbox"/> VASH housing subsidy	<input type="checkbox"/> Emergency Housing Voucher
<input type="checkbox"/> RRH or equivalent subsidy	<input type="checkbox"/> Family Unification Program Voucher (FUP)
<input type="checkbox"/> HCV voucher (tenant or project based, not dedicated)	<input type="checkbox"/> Foster Youth to Independent Initiative (FYI)
<input type="checkbox"/> Public housing unit	<input type="checkbox"/> Permanent Supportive Housing
<input type="checkbox"/> Other permanent housing dedicated for formerly homeless persons	

Other

<input type="checkbox"/> Other	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Worker unable to determine	<input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected

If Other, specify: _____

Current Living Situation
This section is for PROVIDER USE only

Living Situation verified by (Program name): _____

Is client going to have to leave their current living situation within 14 days?

- Yes | No | Client doesn't know | Client prefers not to answer | Data not collected

If Yes, answer the following questions

Has a subsequent residence been identified?

- Yes | No | Client doesn't know | Client prefers not to answer | Data not collected

Does the individual or family have resources or support networks to obtain other permanent housing?

- Yes | No | Client doesn't know | Client prefers not to answer | Data not collected

Has the client had a lease or ownership interest in permanent housing in the last 60 days?

- Yes | No | Client doesn't know | Client prefers not to answer | Data not collected

Has the client moved 2 or more times in the last 60 days?

- Yes | No | Client doesn't know | Client prefers not to answer | Data not collected

Location details:

Date of Engagement
Emergency Shelter, Street Outreach, and Services only

Date of engagement: ____/____/____

Moving on Assistance

Date Moving on Assistance Provided: ____/____/____

- | | |
|--|---|
| <input type="checkbox"/> Subsidized housing application assistance | <input type="checkbox"/> Financial assistance for Moving On |
| <input type="checkbox"/> Non-financial assistance for Moving On | <input type="checkbox"/> Housing referral/placement |

Other (please specify: _____)

Signatures

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