

HMIS Update Form for all HMIS projects

Effective 10/1/2023

Intake Date

			/					/			
--	--	--	---	--	--	--	--	---	--	--	--

Entry Date

			/					/			
--	--	--	---	--	--	--	--	---	--	--	--

**ServicePoint
(HoH) ID:**

--	--	--	--	--	--	--	--

Project Name

--

HoH First Name

--

Middle

--

Last

--

Suffix

--

Alias

--

☐ Full Name Reported

☐ Partial, Street or Code Name

☐ Client doesn't know

☐ Client Refused

**Social Security
Number:**

--	--	--	--	--	--	--	--

☐ Full SSN reported

☐ Approx or Partial SSN

☐ Client doesn't know

☐ Client prefers not to answer

Date of Birth:

			/			/		
--	--	--	---	--	--	---	--	--

☐ Full DOB reported

☐ Approx or Partial DOB

☐ Client doesn't know

☐ Client prefers not to answer

Race and Ethnicity (Select all that apply)

☐ American Indian, Alaska Native, or Indigenous

☐ Native Hawaiian or Pacific Islander

☐ Asian or Asian American

☐ White

☐ Black, African American, or African

☐ Client doesn't know

☐ Hispanic/Latina/e/o

☐ Client prefers not to answer

☐ Middle Eastern or North African

☐ Additional Race and Ethnicity detail: _____

Gender (Select all that apply)

☐ Woman (Girl, if child)

☐ Questioning

☐ Man (Boy, if child)

☐ Different Identity

☐ Culturally Specific Identity (e.g., Two-Spirit)

☐ Client doesn't know

☐ Transgender

☐ Client prefers not to answer

☐ Non-Binary

☐ If Different Identity, Please Specify: _____

Veteran Status

☐ No

☐ Yes

Relationship to Head of Household (Must be an adult)

☐ Self (Head of Household)

☐ HoH's child

☐ HoH's spouse or partner

☐ HoH's other
relation member

☐ Other: non-relation
member

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Housing Move-in Date

		/			/		
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Health Insurance

- | | |
|--|---|
| <input type="checkbox"/> No | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Yes (identify source below) | <input type="checkbox"/> Client prefers not to answer |

Source:

- | | |
|--|--|
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Medicare |
| <input type="checkbox"/> State Children's Health Insurance (KCHIP) | <input type="checkbox"/> Veteran's Health Administration (VHA) |
| <input type="checkbox"/> Employer-Provided Health Insurance | <input type="checkbox"/> Health Insurance obtained through COBRA |
| <input type="checkbox"/> Private Pay Health Insurance | <input type="checkbox"/> State Health Insurance for Adults |
| <input type="checkbox"/> Indian Health Services Program | <input type="checkbox"/> Other: _____ |

Disability

Do you have a physical, mental or emotional impairment, a post-traumatic stress disorder, or brain injury; a development disability, HIV/AIDS, or a diagnosable substance abuse problem?

- | | | | |
|-----------------------------|---|--|---|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes (indicate type(s) below) | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Client prefers not to answer |
|-----------------------------|---|--|---|

	Physical <input type="checkbox"/>	Mental Health <input type="checkbox"/>	Chronic Health Condition <input type="checkbox"/>	<input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs <input type="checkbox"/> Both	Developmental <input type="checkbox"/>	HIV/AIDS <input type="checkbox"/>
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

****IF CLIENT IS A MINOR WHO IS NOT HEAD OF HOUSEHOLD
STOP DATA ENTRY HERE****

Income	
<input type="checkbox"/> No/None at all	<input type="checkbox"/> Yes (identify source and amounts)
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
Source:	Amount:
<input type="checkbox"/> Earned income (i.e., employment income)	\$ _____.00
<input type="checkbox"/> Unemployment Insurance	\$ _____.00
<input type="checkbox"/> Supplemental Security Income (SSI)	\$ _____.00
<input type="checkbox"/> Social Security Disability Income (SSDI)	\$ _____.00
<input type="checkbox"/> Retirement Income from Social Security	\$ _____.00
<input type="checkbox"/> VA Service-Connected Disability Compensation	\$ _____.00
<input type="checkbox"/> VA Non-Service-Connected Disability Pension	\$ _____.00
<input type="checkbox"/> Worker's Compensation	\$ _____.00
<input type="checkbox"/> Temporary Assistance for Needy Families (TANF)	\$ _____.00
<input type="checkbox"/> General Assistance (GA)	\$ _____.00
<input type="checkbox"/> Private disability Insurance	\$ _____.00
<input type="checkbox"/> Pension or retirement income from a former job	\$ _____.00

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<input type="checkbox"/> Child Support	\$ ____ . 00
<input type="checkbox"/> Alimony or other spousal support	\$ ____ . 00
<input type="checkbox"/> Other source: _____	\$ ____ . 00
Total Monthly Income: \$ _____	

Non-Cash Benefits	
<input type="checkbox"/> No/None at all	<input type="checkbox"/> Yes (Identify source below)
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
Source:	
<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP)	
<input type="checkbox"/> Special Supplemental, Nutrition Program for Women, Infants, and Children (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: _____	

Domestic Violence	
Are you, or have you been a survivor of domestic or intimate partner violence?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
If YES, how long ago did you have this experience?	
<input type="checkbox"/> Within the past 3 months	<input type="checkbox"/> 1 year ago or more
<input type="checkbox"/> 3 to 6 months ago	<input type="checkbox"/> 6 months to 1 year ago
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
If Yes, are you currently fleeing?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer

Foster Care	Zip Code of Last Permanent Address
<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>

Staff Completing (Printed Name):	Date:
<input type="text" value=""/>	<input type="text" value=""/>