

HMIS Standard Update Form for HOPWA All Projects

Effective 10/01/2023

Intake Date

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Entry Date

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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 prefers not to answer

Social Security Number:

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☐ Full SSN reported

☐ Approx or Partial SSN

☐ Client doesn't know

☐ Client prefers not to answer

Date of Birth:

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☐ 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

Housing Move-in Date (PSH Only)

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

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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: _____	

Client's Prior Living Situation - Prior to Project Entry				
(Select one Living Situation and answer the corresponding questions in the order in which they appear)				
Homeless Situations	Institutional Situations	Temporary Housing Situations	Permanent Housing Situation	Other
<input type="checkbox"/> Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher, Host Home shelter <input type="checkbox"/> Safe Haven	<input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail, prison or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center	<input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Staying or living in a friend's room, apartment, or house <input type="checkbox"/> Staying or living in a family member's room, apartment, or house	<input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with ongoing housing subsidy <ul style="list-style-type: none"> <input type="checkbox"/> GPD TIP housing subsidy <input type="checkbox"/> VASH housing subsidy <input type="checkbox"/> RRH or equivalent subsidy <input type="checkbox"/> HCV voucher (tenant or project based) (not dedicated) <input type="checkbox"/> Public housing unit <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Emergency Housing Voucher <input type="checkbox"/> Family Unification Program Voucher (FUP) <input type="checkbox"/> Foster Youth to Independence Initiative (FYI) <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Other permanent housing dedicated for formerly homeless persons <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy	<input type="checkbox"/> Other <input type="checkbox"/> Worker unable to determine <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
Length of Stay in Prior Living Situation (i.e. the literally homeless situation identified above)? <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more but less than one month <input type="checkbox"/> One month or more but less than 90 days <input type="checkbox"/> 90 days or more but less than one year <input type="checkbox"/> One year or longer	Length of Stay in Prior Living Situation (i.e. the institutional situation identified above)? <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more but less than one month <input type="checkbox"/> One month or more but less than 90 days <input type="checkbox"/> 90 days or more but less than one year <input type="checkbox"/> One year or longer Did you stay in the institutional situation less than 90 days? <input type="checkbox"/> Yes (If YES – Complete SECTION III) <input type="checkbox"/> No (If NO – End	Length of Stay in Prior Living Situation (i.e. the housing situation identified above)? <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more but less than one month <input type="checkbox"/> One month or more but less than 90 days <input type="checkbox"/> 90 days or more but less than one year <input type="checkbox"/> One year or longer Did you stay in the housing situation less than 7 nights? <input type="checkbox"/> Yes (If YES – Complete SECTION III) <input type="checkbox"/> No (If NO – End Homeless History Interview)	Length of Stay in Prior Living Situation (i.e. the housing situation identified above)? <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more but less than one month <input type="checkbox"/> One month or more but less than 90 days <input type="checkbox"/> 90 days or more but less than one year <input type="checkbox"/> One year or longer Did you stay in the housing situation less than 7 nights? <input type="checkbox"/> Yes (If YES – Complete SECTION III) <input type="checkbox"/> No (If NO – End Homeless History Interview)	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer

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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
HOPWA Project: Medical Assistance	
Receiving AIDS Drug Assistance Program (ADAP)?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
If No, reason (for not receiving ADAP)?	
<input type="checkbox"/> Applied; decision pending	<input type="checkbox"/> Applied; client not eligible
<input type="checkbox"/> Client did not apply	<input type="checkbox"/> Insurance type N/A for this client
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
Receiving Ryan White funded Medical or Dental Assistance?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
If No, reason (for not receiving Ryan White)?	
<input type="checkbox"/> Applied; decision pending	<input type="checkbox"/> Applied; client not eligible
<input type="checkbox"/> Client did not apply	<input type="checkbox"/> Insurance type N/A for this client
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
Has the participant been prescribed anti-retroviral drugs?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer

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HIV/AIDS	
Start Date: [][] / [][] / [][][][]	End Date: [][] / [][] / [][][][]
If Yes for HIV/AIDS, does the client have a T-Cell (CD4) count available?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client prefers not to answer
If Yes for HIV/AIDS and a T-Cell (CD4) count is available, what is the T-Cell (CD4) count?	
If Yes for HIV/AIDS and a T-Cell (CD4) is recorded above, how was the information obtained?	<input type="checkbox"/> Medical report <input type="checkbox"/> Client report <input type="checkbox"/> Other
If Yes for HIV/AIDS, does the client have Viral Load Information available?	<input type="checkbox"/> Not Available <input type="checkbox"/> Available <input type="checkbox"/> Undetectable <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
If Yes for HIV/AIDS and Viral Load Information is available, what is the Viral Load?	
If Yes for HIV/AIDS and Viral Load is recorded above, how was the information obtained?	<input type="checkbox"/> Medical report <input type="checkbox"/> Client report <input type="checkbox"/> Other

Staff Completing (Printed Name):

Date:

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