

HMIS Annual/Update Form Outreach

Client ID: _____

Information Date _____

Staff Completing HMIS Form: _____

Identification - All fields required unless otherwise noted

During Program Enrollment _____ Annual _____

First Name _____ Middle Name _____

Last Name _____ Suffix _____

Social Security Number (SSN)	Birth Date (DOB)	Date of Engagement
____-____-____	____/____/____	____/____/____

Assessment Type

During Program Enrollment _____ Annual Assessment _____

Health Insurance

Yes (Enter the Source) No Client Doesn't Know Client Refused

Health Insurance Sources

<input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> MEDICAID <input type="checkbox"/> State Children's Health Insurance(SCHIP) <input type="checkbox"/> VA Medical Services	<input type="checkbox"/> Employer Provided Health Insurance <input type="checkbox"/> Health Insurance obtained through COBRA <input type="checkbox"/> State Health Insurance Adults (Medi-cal) <input type="checkbox"/> Indian Health Services Program Other: _____
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Veteran (Have you ever served in the U.S. Military?) 18 and Over Yes No Don't Know Client Refused

Barriers:

	Barrier Present	Condition is Indefinite
Alcohol Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
Chronic Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
Development Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
Mental health	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
Physical Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused

Domestic Violence

Is the client a domestic violence victim/survivor?	<input type="checkbox"/> Yes (Answer questions below) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
If yes, How long ago did you have this experience?	<input type="checkbox"/> Within the past 3 months <input type="checkbox"/> 3 months to 6 months ago <input type="checkbox"/> 6 months to one year	<input type="checkbox"/> One year ago or more <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
If yes, are you currently fleeing?	<input type="checkbox"/> Yes (Answer questions below) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	

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Financial Assessment (Check all that Apply and Enter amount)			
Income Source (Check all that apply)	Stated Income (Monthly)	Non-Cash Resources (Check all that apply)	Stated Amounts (Monthly)
<input type="checkbox"/> Yes (Check all Sources that Apply) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		<input type="checkbox"/> Yes (Check all Sources that Apply) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
<input type="checkbox"/> Earned Income (<i>employment wages / cash</i>)	\$	<input type="checkbox"/> Special Supplemental nutritional Program Women and Children	\$
<input type="checkbox"/> Unemployment Insurance	\$	<input type="checkbox"/> Food Stamps (CalFresh) SNAP	\$
<input type="checkbox"/> Supplemental Security Income (SSI)	\$	<input type="checkbox"/> CalWorks Child Care/TANF Child Care Services	\$
<input type="checkbox"/> Social Security Disability Income (SSDI)	\$	<input type="checkbox"/> CalWorks Transportation (TANF)	\$
<input type="checkbox"/> Private Disability Insurance	\$	<input type="checkbox"/> Other CalWorks-Funded Services (TANF)	\$
<input type="checkbox"/> Workers Compensation	\$	<input type="checkbox"/> Other	\$
<input type="checkbox"/> VA Service-Connected Disability Compensation	\$		
<input type="checkbox"/> VA Non-Service-Connected Disability Pension	\$		
<input type="checkbox"/> Pension or Retirement income from a job	\$		
<input type="checkbox"/> TANF	\$		
<input type="checkbox"/> General Assistance	\$		
<input type="checkbox"/> Retirement (Social Security)	\$		
<input type="checkbox"/> Child Support	\$		
<input type="checkbox"/> Alimony or other Spousal Support	\$		
<input type="checkbox"/> Other Income	\$		

Contact	
Date of Contact (E.G. 05/24/2010)	____/____/____
As of today, is the client staying on the Streets, Emergency Shelter, or Safe Haven?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Worker unable to determine