HMIS Annual/Update Form

Client ID: _____

Information Date _____

Staff Completing HMIS Form: _____

Identification *- All fields required unless otherwise noted*

First Name _____ **Middle Name** _____

Last Name **Suffix**

Social Security Number (SSN)	Birth Date (DOB)	Housing Move in Date(Rapid Rehousing ONLY)
_____-_____-_____	_____/_____/_____	_____/_____/_____

Assessment Type

During Program Enrollment		Annual Assessment		

Wellness Assessment

Health Insurance

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

Health Insurance Sources

□ Private Pay Health Insurance □ Medicare □ MEDICAID □ State Children's Health Insurance(SCHIP) □ VA Medical Services	□ Employer Provided Health Insurance □ Health Insurance obtained through COBRA □ State Health Insurance Adults (Medi-cal) □ Indian Health Services Program Other:_____
Pregnancy Status (RHY ONLY)	□ Yes* (Due Date _____) □ No □ Client Doesn't Know □ Client Refused
Connection with SOAR (SSVF Only)	□ Yes □ No □ Client Doesn't Know □ Client Refused

Barriers:

	Barrier Present	Condition is Indefinite
Alcohol Abuse	□ Yes □ No □ Don't Know □ Client Refused	□ Yes □ No □ Don't Know □ Client Refused
Chronic Health Condition	□ Yes □ No □ Don't Know □ Client Refused	□ Yes □ No □ Don't Know □ Client Refused
Development Disability	□ Yes □ No □ Don't Know □ Client Refused	□ Yes □ No □ Don't Know □ Client Refused
Drug Abuse	□ Yes □ No □ Don't Know □ Client Refused	□ Yes □ No □ Don't Know □ Client Refused
HIV/AIDS	□ Yes □ No □ Don't Know □ Client Refused	□ Yes □ No □ Don't Know □ Client Refused
Mental health	□ Yes □ No □ Don't Know □ Client Refused	□ Yes □ No □ Don't Know □ Client Refused
Physical Disability	□ Yes □ No □ Don't Know □ Client Refused	□ Yes □ No □ Don't Know □ Client Refused

Domestic Violence

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

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