

Effective 10/01/2023

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☐ Client prefers not to answer

☐ Client prefers not to answer

☐ Client prefers not to answer

☐ Client prefers not to answer

☐ Other: non-relation member

HMIS Standard Update Form for VA SSVF projects

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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"/>

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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: \$ _____	

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

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SOAR Connection

Connection with SOAR

- ☐ No ☐ Yes
☐ Client doesn't know ☐ Client prefers not to answer

Employed?	
<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, Type of Employment	
<input type="checkbox"/> Full-Time	<input type="checkbox"/> Seasonal/sporadic (including day labor)
<input type="checkbox"/> Part-Time	<input type="checkbox"/> Data not collected
In No, Why not Employed	
<input type="checkbox"/> Looking for work	<input type="checkbox"/> Not looking for work
<input type="checkbox"/> Unable to work	<input type="checkbox"/> Data not collected