



# HMIS Standard Interim Form for VA GPD projects

Effective 10/01/2023

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						
<b>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?</b>						
<input type="checkbox"/> No answer	<input type="checkbox"/> Yes (indicate type(s) below)		<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to		
	<b>Physical</b> <input type="checkbox"/>	<b>Mental Health</b> <input type="checkbox"/>	<b>Chronic Health Condition</b> <input type="checkbox"/>	<input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs <input type="checkbox"/> Both	<b>Developmental</b> <input type="checkbox"/>	<b>HIV/AIDS</b> <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

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

## 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 |

## Veteran Information

### Year entered military service:

<input type="text"/>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
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World War II

Korean War

Vietnam War

Persian Gulf War

Afghanistan

Iraq Freedom

Iraq Dawn

Other Peace-keeping Operations or Military Interventions

### Year separated from military service:

<input type="text"/>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
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<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client prefers not to answer
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<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client prefers not to answer
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<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client prefers not to answer
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<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client prefers not to answer
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<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client prefers not to answer
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<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client prefers not to answer
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<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client prefers not to answer
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<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client prefers not to answer
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Branch of the Military

<input type="checkbox"/> Army	<input type="checkbox"/> Air Force	<input type="checkbox"/> Navy
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Discharge Status

- |                                              |                                                    |
|----------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Marines             | <input type="checkbox"/> Coast Guard               |
| <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Client prefers not answer |
| <input type="checkbox"/> Data not collected  | <input type="checkbox"/> Space Force               |

- |                                                                |
|----------------------------------------------------------------|
| <input type="checkbox"/> Honorable                             |
| <input type="checkbox"/> General under honorable conditions    |
| <input type="checkbox"/> Under other than honorable conditions |
| <input type="checkbox"/> Bad Conduct                           |
| <input type="checkbox"/> Dishonorable                          |
| <input type="checkbox"/> Uncharacterized                       |
| <input type="checkbox"/> Client doesn't know                   |
| <input type="checkbox"/> Client prefers not answer             |
| <input type="checkbox"/> Data not collected                    |

VAMC Station Number

SOAR Connection

## Connection with SOAR

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

Employed?

- |                                              |                             |
|----------------------------------------------|-----------------------------|
| <input type="checkbox"/> Yes                 | <input type="checkbox"/> No |
| <input type="checkbox"/> Data Not Collected  |                             |
| <input type="checkbox"/> Client Doesn't Know |                             |

If No, why not employed:

Staff Completing (Printed Name):

Date: