Client ID: _____
Project Name: _____
Information Date: _____
Staff Name: _____

# HMIS Annual/Update Form

*For Person in HMIS Projects*: ***ALL <u>except Outreach</u>***

**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)** |
|---|---|---|
| _____-____-_____ | _____/_____/_____ | _____/_____/_____ |

**Mailing Address and Contact Information** *(Includes, not limited to, service organizations, access centers, emergency shelter, transitional housing, client residence)*

Address: _____
City, State, Zip Code: _____
Email: _____
Main Phone: _____
Message Phone: _____

| **Assessment Type** | ☐During Program Enrollment ☐Annual Assessment |
|---|---|

**Wellness Assessment**

**Health Insurance**

☐Yes *(Enter Source)* ☐No ☐Client doesn't know ☐Client prefers not to answer

**Health Insurance Source** *(Check all that apply)*

| | |
|---|---|
| ☐Private Pay Health Insurance | ☐Medicare |
| ☐MEDICAID | ☐Health Net (Medi-Cal)-Adults |
| ☐Health Net (Medi-Cal)-Children | ☐Health Plan of San Joaquin (Medi-Cal)-Adults |
| ☐Health Plan of San Joaquin (Medi-Cal)-Children | ☐State Children's Health Insurance (Medi-Cal) |
| ☐Veteran's Health Administration (VHA) | ☐Employer Provided Health Insurance |
| ☐Health Insurance obtained through COBRA | ☐State Funded Insurance for Adults (Medi-Cal) |
| ☐Indian Health Services Program (IHS) | ☐Other: _____ |

**Veterans** ***(Have you ever served in the U.S. Military?) 18 and over***

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

**Connection with SOAR?** *(SSVF Only)*

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

**Barriers** *(For During Program Enrollment Only)*

| | **Barrier Present** | **Condition Is Indefinite** |
|---|---|---|
| ☐Alcohol Use Disorder | ☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer | ☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer |
| ☐Chronic Health Condition | ☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer | ☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer |
| ☐Developmental Disability | ☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer | |
| ☐Drug Use Disorder | ☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer | ☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer |
| ☐HIV/AIDS | ☐Yes ☐No ☐Doesn't know ☐Client Prefers Not to Answer | |

| | | |
|---|---|---|
| ☐Mental Health Disorder | ☐Yes ☐No ☐Doesn't know<br>☐Client prefers not to answer | ☐Yes ☐No ☐Doesn't know<br>☐Client prefers not to answer |
| ☐Physical Disability | ☐Yes ☐No ☐Doesn't know<br>☐Client prefers not to answer | ☐Yes ☐No ☐Doesn't know<br>☐Client prefers not to answer |

**Domestic Violence Survivor** *(For During Program Enrollment Only)*

**Domestic Violence Experience?**

☐Yes *(Answer questions below)* ☐No ☐Client doesn't know ☐Client prefers not to answer

**When Experience Occurred?**

☐Within the past 3 months ☐3 months to 6 months ago *(excluding 6 mos exactly)*
☐6 months to one year ago *(excluding 1 year exactly)* ☐One year ago or more
☐Client doesn't know ☐Client prefers not to answer

**If Yes, are you currently fleeing?**

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

**Financial Assessment**

**Does client have any source of income?** (*If Yes, check all that apply)*

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

| Income Source | Monthly Amount |
|---|---|
| ☐Earned Income (employment wages/cash) | $ |
| ☐Unemployment Insurance | $ |
| ☐Supplemental Security Income (SSI) | $ |
| ☐Social Security Disability Income (SSDI) | $ |
| ☐Private Disability Insurance | $ |
| ☐Worker's Compensation | $ |
| ☐VA Service-Connected Disability | $ |
| ☐VA Non-Service-Connected Disability Pension | $ |
| ☐Pension or Retirement Income from a job | $ |
| ☐TANF (CalWorks) | $ |
| ☐General Assistance | $ |
| ☐Retirement (Social Security) | $ |
| ☐Child Support | $ |
| ☐Alimony | $ |
| ☐Other Income | $ |

**Does client have any Non-Cash Benefits?** *(If Yes, check all that apply)*

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

| Non-Cash Benefits | Monthly Amount |
|---|---|
| ☐Special Supplemental Nutrition Program for Woman, Infants, and Children | $ |
| ☐Food Stamps (CalFresh) SNAP | $ |
| ☐CalWorks Child Care/TANF Child Care Services | $ |
| ☐CalWorks Transportation (TANF) | $ |
| ☐Other CalWorks-Funded Services (TANF) | $ |
| ☐Other Sources | $ |

**Pregnancy Status** *(RHY Only)*

☐Yes* (Due Date _____) ☐No ☐Client doesn't know ☐Client prefers not to answer