

HMIS # _____
Client Name _____
Staff Name _____
Date _____

## Santa Cruz County HMIS - SSVF Status Assessment

The service provider should complete this form while interviewing a client. Complete a separate Standard Update form for each household member. This form must be completed each year a client has been enrolled in a specific program. The form should also be completed when staff know a client's status has changed so that key information gets updated.

### Temporary or Permanent Address

<p><u>If the client is living in temporary or permanent housing, please note the address of the residence.</u></p> <p><b>IMPORTANT REMINDER:</b> when client moves into a permanent housing unit while enrolled in Rapid Rehousing, Permanent Supportive Housing or Other Permanent Housing programs, ensure the "Housing Move-In Date" on enrollment screen is completed.</p>	<p><b>Street Address</b> _____</p> <p><b>City</b> _____</p>																				
	<p><b>State</b> _____</p> <p><b>Zip Code</b> _____</p>																				
<p>Move-in Date (when needed to complete the Housing Move-In Date on the enrollment screen)</p>	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;">/</td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;">/</td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> </tr> <tr> <td colspan="3">Month</td> <td colspan="3">Day</td> <td colspan="4">Year</td> </tr> </table>			/			/					Month			Day			Year			
		/			/																
Month			Day			Year															

### Disabling Conditions

<p><b>1) Does the client currently have a disabling condition?</b></p> <p><i>A Disabling Condition is health condition that interferes with getting and/or keeping stable housing.</i></p> <p><i>This question is used with other information to determine if the client meets criteria for chronic homelessness.</i></p> <p><b>All questions in this section MUST be answered even if the answer is "no" to this question.</b></p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Client Doesn't Know</p> <p><input type="checkbox"/> Client Refused</p>
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Client Name \_\_\_\_\_

Head of Household Name (if not Self) \_\_\_\_\_

<p><b>2) Does the client have a Physical Disability?</b></p> <p><i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
<p><b>3) Does the client have a Developmental Disability?</b></p> <p><i>If Yes, is it expected to substantially impair the client's ability to live independently?</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
<p><b>4) Does the client have a Chronic Health Condition?</b></p> <p><i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
<p><b>5) Does the client have HIV – AIDS?</b></p> <p><i>If Yes, is it expected to substantially impair the client's ability to live independently?</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
<p><b>6) Does the client have a Mental Health Disorder?</b></p> <p><i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
<p><b>7) Does the client have a Substance Use Disorder?</b></p> <p><i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i></p>	<input type="checkbox"/> No <input type="checkbox"/> Alcohol use disorder <input type="checkbox"/> Drug use disorder <input type="checkbox"/> Both Alcohol & Drug use disorders	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

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## Domestic Violence

<p><b>1) Domestic Violence Victim/Survivor</b>  <i>Ask the client "Have you ever experienced any domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions against you or a member of your family, including a child, that has happened in the place you were living?"</i></p> <p><i>If the answer is "no", skip to "Monthly Income – Cash Benefits" section</i></p> <p><i>If the answer is "yes", COMPLETE questions 2 and 3.</i></p>	<p><input type="checkbox"/> Yes <span style="float: right;"><input type="checkbox"/> Client Doesn't Know</span>  <input type="checkbox"/> No <span style="float: right;"><input type="checkbox"/> Client Refused</span></p>
<p><b>2) Most Recent Occurrence</b>  <i>Ask the client "How long ago was your most recent experience of domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions?"</i></p>	<p><input type="checkbox"/> Within the past three months  <input type="checkbox"/> Three to six months ago (excluding six months exactly)  <input type="checkbox"/> Six months to one year ago (excluding one year exactly)  <input type="checkbox"/> One year ago or more  <input type="checkbox"/> Client Doesn't Know  <input type="checkbox"/> Client Refused</p>
<p><b>3) Current Status</b>  <i>Ask the client "Are you currently fleeing, or attempting to flee, the domestic violence situation, or are you afraid to return to the place you are living?"</i></p>	<p><input type="checkbox"/> Yes <span style="float: right;"><input type="checkbox"/> Client Doesn't Know</span>  <input type="checkbox"/> No <span style="float: right;"><input type="checkbox"/> Client Refused</span></p>

Client Name \_\_\_\_\_

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**Monthly Income – Cash Benefits**

<p><b>Current income from any source?</b>  <i>Is the client currently receiving any income from any source?</i></p>	<p><input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> Client doesn't know   <input type="checkbox"/> Client refused</p>
<p><b>Specify the type(s) and amount(s) of income the client currently receives.</b></p>	<p><input type="checkbox"/> Earned Income \$ _____</p> <p><input type="checkbox"/> Unemployment Insurance \$ _____</p> <p><input type="checkbox"/> Supplemental Security Income SSI \$ _____</p> <p><input type="checkbox"/> Social Security Disability Insurance SSDI \$ _____</p> <p><input type="checkbox"/> VA Service-Connected Disability Pension \$ _____</p> <p><input type="checkbox"/> VA Non-service connect disability pension \$ _____</p> <p><input type="checkbox"/> Private Disability Insurance \$ _____</p> <p><input type="checkbox"/> Worker's Compensation \$ _____</p> <p><input type="checkbox"/> Temporary Assistance for Needy Families TANF/CalWORKs \$ _____</p> <p><input type="checkbox"/> General Assistance (GA) \$ _____</p> <p><input type="checkbox"/> Retirement income from Social Security \$ _____</p> <p><input type="checkbox"/> Pension or Retirement Income from a Former Job \$ _____</p> <p><input type="checkbox"/> Child Support \$ _____</p> <p><input type="checkbox"/> Alimony and Other Spousal Support \$ _____</p> <p><input type="checkbox"/> Other Cash Income \$ _____</p> <p>If Other Specify: _____</p>
<p><b>Total Cash Income for Individual</b></p>	<p><b>TOTAL: \$ _____</b></p>

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### Non-Cash Benefits

<p><b>Currently receiving Non-Cash Benefits?</b>  <i>Is the client currently receiving one of the non-cash benefits listed below?</i></p> <p><b>If Yes, indicate all the non-cash benefits the client is receiving:</b></p> <p><i>Only regular, recurrent sources that are current today should be included. Record non-cash benefits received by a minor member (under 18 years of age) of the household under the HoH's information.</i></p> <p><i>DO NOT include benefits received by other adults (18 years and older) in the household; record their benefits on their Annual/Update form.</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
	<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP)/CalFresh <input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) <input type="checkbox"/> TANF/CALWORKS Childcare Services <input type="checkbox"/> TANF/CALWORKS Transportation Services <input type="checkbox"/> Other TANF/CALWORKS-Funded Services <input type="checkbox"/> Other Non-Cash Benefit If Other Specify: _____

### Health Insurance

<p><b>Currently covered by health insurance?</b>  <i>Is the client currently covered by health insurance?</i></p> <p><b>If Yes, type(s) of insurance(s)</b></p> <p><i>If the client is currently covered by multiple health insurances please select all that apply.</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
	<input type="checkbox"/> Medicaid (same as Medi-Cal) <input type="checkbox"/> Medicare <input type="checkbox"/> State Children's Health Insurance (CHIP) Program <input type="checkbox"/> Veteran's Administration (VA) Medical Services <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 Health Insurance If Other Specify: _____

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### Connection with SOAR

<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client refused <input type="checkbox"/> Client doesn't know
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### Employment Status

<b>Currently Employed?</b> <i>Is the client currently employed?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused
<b>If Yes, specify the type of employment</b>	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Seasonal/Sporadic (including day labor)
<b>If No, is the client looking for employment?</b>	<input type="checkbox"/> Looking for work <input type="checkbox"/> Unable to work <input type="checkbox"/> Not looking for work

### Education Status

<b>Specify the last grade of school completed by the client</b>	<input type="checkbox"/> Less than Grade 5 <input type="checkbox"/> Grades 5-6 <input type="checkbox"/> Grades 7-8 <input type="checkbox"/> Grades 9-11 <input type="checkbox"/> Grade 12/ High school diploma <input type="checkbox"/> School program does not have grade levels	<input type="checkbox"/> GED <input type="checkbox"/> Some college <input type="checkbox"/> Associate's degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Graduate degree <input type="checkbox"/> Vocational certification <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
<b>Is the client <u>currently</u> enrolled in school or a training program?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Client Refused	
<b>If Yes, specify the type of school or training program</b>	<input type="checkbox"/> Kindergarten – 8 <sup>th</sup> grade <input type="checkbox"/> High School <input type="checkbox"/> Community College <input type="checkbox"/> Vocational Program	<input type="checkbox"/> Training Program <input type="checkbox"/> University <input type="checkbox"/> Other

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### General Health Status (Head of Household Only)

1) Clients' general health status.	<input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very Good <input type="checkbox"/> Excellent <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
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