

IF "YES" TO CHRONIC HEALTH CONDITION - SPECIFY



## San Francisco ONE System: HHS-RHY PROGRAM STATUS UPDATE FORM

Use block letters for text and bubble in the appropriate circles. Please complete a separate form for each household member.

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	ES" TO	PERI	MANE	ENT H	ousi	NG	1 1				
Hous	sing Mo	ve-In	Date:	*				/_			
*If cli	ient mov	ed inte	o pern	nanen	t hous	sing, m	ake s	sure t	o upda	ate on i	the enrollment screen.
DISA	BLING	CON	DITIC	N [A	II Clie	ents]					
0 N	lo									0	Client doesn't know
0 Y	es									0	Client prefers not to answer
										0	Data not collected
PHYS	SICAL E	DISAE	BILIT	<b>Y</b> [All	Clien	ts]					
o N	10									0	Client doesn't know
0 Y	'es									0	Client prefers not to answer
										0	Data not collected
IF "Y	ES" TO	PHY	SICAL	_ DISA	BILIT	ΓY – S	PECI	FY			
Expe	ected to I	be of l	ong-c	ontinu	ed an	d inde	finite	0	No	0	Client doesn't know
	tion and		antiall	y impa	airs ab	ility to	live	0	Yes	0	Client prefers not to answer
indep	pendentl	y?								0	Data not collected
DEVE	ELOPM	ENTA	L DIS	SABIL	LITY	[All Cl	ients	1			
0 N	10					-		_		0	Client doesn't know
0 Y	'es									0	Client prefers not to answer
										0	Data not collected
IF "Y	ES" TO	DEVI	ELOP	MENT	AL D	ISABI	LITY	– SP	ECIFY	7	
	ected to							0	No	0	Client doesn't know
	tion and							0	Yes	0	Client prefers not to answer
	pendentl					•		<u> </u>		0	Data not collected
										1	,
	ONIC H	EAI T	HCC	דוחאכ	ION	IAII CI	ients	:1			
CHRO	ONIC H	EALT	НСС	DNDIT	ION	[All Cl	ients	<u>s]</u>			Client doesn't know
CHR(	ONIC H lo 'es	EALT	НСС	DNDIT	ION	[All Cl	ients	s]		0	Client doesn't know Client prefers not to answer



Expected to be of long-continued and indefinite	0	No	0	Client doesn't know
duration and substantially impairs ability to live	0	Yes	0	Client prefers not to answer
independently?			0	Data not collected

HIV-AIDS [All Clients]

0	No			0	Client doesn't know
0	Yes			0	Client prefers not to answer
				0	Data not collected
IF	"YES" TO HIV-AIDS – SPECIFY				
	pected to be of long-continued and	0	No	0	Client doesn't know
ine	definite duration and substantially impairs	0	Yes	0	Client prefers not to answer
ab	ility to live independently?			0	Data not collected

**MENTAL HEALTH DISORDER** [All Clients]

o No			0	Client doesn't know
○ Yes			0	Client prefers not to answer
			0	Data not collected
IF "YES" TO MENTAL HEALTH DISORDER - S	SPE	CIFY		
Expected to be of long-continued and indefinite	0	No	0	Client doesn't know
duration and substantially impairs ability to live	0	Yes	0	Client prefers not to answer
independently?			0	Data not collected

**SUBSTANCE USE DISORDER** [All Clients]

0	No			0	Client doesn't know
0	Alcohol use disorder	0	Client prefers not to answer		
0	Drug use disorder	0	Data not collected		
0	Both alcohol and drug use disorders				
IF	"ALCOHOL USE DISORDER" "DRUG USE	DIS	ORDER"	OR "	BOTH ALCOHOL AND DRUG USE
	"ALCOHOL USE DISORDER" "DRUG USE SORDERS" – SPECIFY	DIS	ORDER"	OR "	BOTH ALCOHOL AND DRUG USE
DI		DIS o	ORDER"	OR "	BOTH ALCOHOL AND DRUG USE  Client doesn't know
DI Ex	SORDERS" – SPECIFY			-	

INCOME FROM ANY SOURCE [Head of Household and Adults]

0	No	(	0	Client doesn't know				
0	O Yes			Client prefers not to answer				
				Data not collected				
IF	"YES" TO INCOME FROM ANY SOURCE – IN	IDICATE A	ALL SC	DURCES THAT APPLY				
Inc	come Source	Amount	Inco	ome Source	Amount			
0	Earned Income		0	CalWORKs				
0	Unemployment Insurance		0	CAAP				
0	Supplemental Security Income (SSI)		0	Retirement income from Social Security				
0	Social Security Disability Insurance (SSDI)		0	Pension or retirement income from a former job				
0	VA Service-Connected Disability Compensation		0	Child support				
0	VA Non-Service-Connected Disability Pension		0	Alimony and other spousal support				



0	Private disability insurance	0	Other income source (specify):	
0	Worker's Compensation			
То	tal Monthly Income for Individual:			

**RECEIVING NON-CASH BENEFITS [Head of Household and Adults]** 

	<b>_</b>		
0	No	0	Client doesn't know
0	Yes	0	Client prefers not to answer
		0	Data not collected
IF	"YES" TO NON-CASH BENEFITS – INDICATE ALL SOURCES THAT AP	PLY	
0	CalFresh	0	CalWORKs Child Care Services
0	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	0	CalWORKs Transportation Services
0	Other (specify):	0	CalWORKs TANF-funded services

**COVERED BY HEALTH INSURANCE [All Clients]** 

	<u>-</u>		
0	No	0	Client doesn't know
0	Yes	0	Client prefers not to answer
		0	Data not collected
IF '	"YES" TO HEALTH INSURANCE – HEALTH INSURANCE	COV	ERAGE DETAILS
0	Medi-Cal	0	Employer Provided Health Insurance
0	MEDICARE	0	Health Insurance Obtained Through COBRA
0	State Children's Health Insurance (SCHIP)	0	Private Pay Health Insurance
0	Veteran's Health Administration (VHA)	0	State Health Insurance for Adults
0	Other (specify):	0	Indian Health Services Program

## RHY SPECIFIC YOUTH INFORMATION

PREGNANCY STATUS [Adults and Head of Household]

o No	Client doesn't know
○ Yes	Client prefers not to answer
	Data not collected
If "Yes" for Pregnancy Status	
Due Date	

Signature of applicant stating all information is true and correct

**Date**