

Agency Name: _____



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.

CLIENT NAME OR IDENTIFIER: _____

PROJECT STATUS DATE *[All Clients]*

		/			/			
Month			Day			Year		

IN PERMANENT HOUSING *[Permanent Housing Projects, for Head of Household]*

<input type="radio"/> No	<input type="radio"/> Yes
IF "YES" TO PERMANENT HOUSING	
Housing Move-In Date:*	____/____/____
<i>*If client moved into permanent housing, make sure to update on the enrollment screen.</i>	

DISABLING CONDITION *[All Clients]*

<input type="radio"/> No	<input type="radio"/> Client doesn't know
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
	<input type="radio"/> Data not collected

PHYSICAL DISABILITY *[All Clients]*

<input type="radio"/> No	<input type="radio"/> Client doesn't know	
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer	
	<input type="radio"/> Data not collected	
IF "YES" TO PHYSICAL DISABILITY – SPECIFY		
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	<input type="radio"/> No	<input type="radio"/> Client doesn't know
	<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
		<input type="radio"/> Data not collected

DEVELOPMENTAL DISABILITY *[All Clients]*

<input type="radio"/> No	<input type="radio"/> Client doesn't know	
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer	
	<input type="radio"/> Data not collected	
IF "YES" TO DEVELOPMENTAL DISABILITY – SPECIFY		
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	<input type="radio"/> No	<input type="radio"/> Client doesn't know
	<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
		<input type="radio"/> Data not collected

CHRONIC HEALTH CONDITION *[All Clients]*

<input type="radio"/> No	<input type="radio"/> Client doesn't know
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
	<input type="radio"/> Data not collected
IF "YES" TO CHRONIC HEALTH CONDITION – SPECIFY	

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	<input type="radio"/> No	<input type="radio"/>	Client doesn't know
	<input type="radio"/> Yes	<input type="radio"/>	Client prefers not to answer
		<input type="radio"/>	Data not collected

HIV-AIDS [All Clients]

<input type="radio"/> No	<input type="radio"/>	Client doesn't know	
<input type="radio"/> Yes	<input type="radio"/>	Client prefers not to answer	
	<input type="radio"/>	Data not collected	
IF "YES" TO HIV-AIDS – SPECIFY			
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	<input type="radio"/> No	<input type="radio"/>	Client doesn't know
	<input type="radio"/> Yes	<input type="radio"/>	Client prefers not to answer
		<input type="radio"/>	Data not collected

MENTAL HEALTH DISORDER [All Clients]

<input type="radio"/> No	<input type="radio"/>	Client doesn't know	
<input type="radio"/> Yes	<input type="radio"/>	Client prefers not to answer	
	<input type="radio"/>	Data not collected	
IF "YES" TO MENTAL HEALTH DISORDER – SPECIFY			
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	<input type="radio"/> No	<input type="radio"/>	Client doesn't know
	<input type="radio"/> Yes	<input type="radio"/>	Client prefers not to answer
		<input type="radio"/>	Data not collected

SUBSTANCE USE DISORDER [All Clients]

<input type="radio"/> No	<input type="radio"/>	Client doesn't know	
<input type="radio"/> Alcohol use disorder	<input type="radio"/>	Client prefers not to answer	
<input type="radio"/> Drug use disorder	<input type="radio"/>	Data not collected	
<input type="radio"/> Both alcohol and drug use disorders			
IF "ALCOHOL USE DISORDER" "DRUG USE DISORDER" OR "BOTH ALCOHOL AND DRUG USE DISORDERS" – SPECIFY			
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	<input type="radio"/> No	<input type="radio"/>	Client doesn't know
	<input type="radio"/> Yes	<input type="radio"/>	Client prefers not to answer
		<input type="radio"/>	Data not collected

INCOME FROM ANY SOURCE [Head of Household and Adults]

<input type="radio"/> No	<input type="radio"/>	Client doesn't know	
<input type="radio"/> Yes	<input type="radio"/>	Client prefers not to answer	
	<input type="radio"/>	Data not collected	
IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY			
Income Source	Amount	Income Source	Amount
<input type="radio"/> Earned Income		<input type="radio"/> CalWORKs	
<input type="radio"/> Unemployment Insurance		<input type="radio"/> CAAP	
<input type="radio"/> Supplemental Security Income (SSI)		<input type="radio"/> Retirement income from Social Security	
<input type="radio"/> Social Security Disability Insurance (SSDI)		<input type="radio"/> Pension or retirement income from a former job	
<input type="radio"/> VA Service-Connected Disability Compensation		<input type="radio"/> Child support	
<input type="radio"/> VA Non-Service-Connected Disability Pension		<input type="radio"/> Alimony and other spousal support	

<input type="checkbox"/>	Private disability insurance		<input type="checkbox"/>	Other income source (<i>specify</i>):	
<input type="checkbox"/>	Worker's Compensation				
Total Monthly Income for Individual:					

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

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

COVERED BY HEALTH INSURANCE [All Clients]

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

RHY SPECIFIC YOUTH INFORMATION

PREGNANCY STATUS [Adults and Head of Household]

<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client prefers not to answer
		<input type="checkbox"/>	Data not collected
If "Yes" for Pregnancy Status			
Due Date		____/____/____	

Signature of applicant stating all information is true and correct Date