



## Marin County Continuum of Care

## Standard HMIS Adult Client Status Update and/or Annual Assessment

Program Name: \_\_\_\_\_ Case Worker/Intake Person: \_\_\_\_\_ Status Date: \_\_\_\_\_

### CLIENT STATUS UPDATE/ANNUAL ASSESSMENT

**Status Update Assessment** is to be filled out every time there is a change in disabilities, income, non-cash benefits, or health insurance.

**Annual Assessment** is to be filled out once a year – 30 days before or after the anniversary of the program start date.

Complete this form if the client is an adult or Head of Household. A separate Standard Adult Client Status Update or Annual Assessment must be completed for each adult member of the household. A separate Status Update or Annual Assessment form must be completed for children (non-Head of Household) as well, but please be sure to use the Standard Child Status Update or Annual Assessment form.

<b>1) Client Name</b>	<b>First</b>	<b>Last</b>																				
<b>2) Project Status Update or Annual Assessment Date</b>	<table border="1"> <tr> <td></td><td></td><td>/</td><td></td><td></td><td>/</td><td></td><td></td><td></td><td></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																
<b>3) Housing Move-in Date</b> [Head of Household only]  <i>(Required for Permanent Housing Projects only)</i>  <b>IMPORTANT REMINDER:</b> When a 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.	<table border="1"> <tr> <td></td><td></td><td>/</td><td></td><td></td><td>/</td><td></td><td></td><td></td><td></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																
<b>DISABLING CONDITIONS:</b> A Disabling Condition is a health condition that interferes with getting and/or keeping stable housing.																						
<b>1) Does the client have a Physical Disability?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</b> <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"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected  <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected																				
<b>2) Does the client have a Developmental Disability?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer																				

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

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

		<input type="checkbox"/> Data Not Collected
3) Does the client have a Chronic Health Condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
4) Does the client have HIV – AIDS?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
5) Does the client have a Mental Health Disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
6) Does the client have any Substance Use Disorder?	<input type="checkbox"/> No <input type="checkbox"/> Alcohol use disorder <input type="checkbox"/> Drug use disorder <input type="checkbox"/> Both Alcohol & Drug Abuse Use Disorders	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected

**DOMESTIC VIOLENCE [Head of Household and Adults only]**

<b>1) Survivor of Domestic Violence</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>  <b>If the answer is "no", skip to "Monthly Income – Cash Benefits" section.</b>  <b>If the answer is "yes", COMPLETE questions 2 and 3.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
<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>	<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 prefers not to answer

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

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

		<input type="checkbox"/> Data Not Collected
<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>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
<b>MONTHLY INCOME – CASH BENEFITS [Head of Household and Adults only]</b>		
<b>Current income from any source?</b> <i>Is the client currently receiving any income from any source?</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
<b>Specify the type(s) and amount(s) of income the client currently receives.</b>  <i>Only regular, recurrent sources that are current today should be included. Income received for a minor (under 18 years old) member of the household (e.g., SSI) should be recorded with the HoH's information.</i>  <i>DO NOT include income received by other adults (18 years and older) in the household; record their income on their Enrollment form.</i>		<input type="checkbox"/> Earned Income \$ _____ <input type="checkbox"/> Unemployment Insurance \$ _____ <input type="checkbox"/> Supplemental Security Income SSI \$ _____ <input type="checkbox"/> Social Security Disability Insurance SSDI \$ _____ <input type="checkbox"/> VA Service-Connected Disability Pension \$ _____ <input type="checkbox"/> VA Non-service connect disability pension \$ _____ <input type="checkbox"/> Private Disability Insurance \$ _____ <input type="checkbox"/> Worker's Compensation \$ _____ <input type="checkbox"/> Temporary Assistance for Needy Families TANF/CalWORKs \$ _____ <input type="checkbox"/> General Assistance (GA) \$ _____ <input type="checkbox"/> Retirement income from Social Security \$ _____ <input type="checkbox"/> Pension or Retirement Income from a Former Job \$ _____ <input type="checkbox"/> Child Support \$ _____ <input type="checkbox"/> Alimony and Other Spousal Support \$ _____ <input type="checkbox"/> Other Cash Income \$ _____ If Other Specify: _____
<b>Total Monthly Cash Income for Individual</b>		<b>TOTAL: \$ _____</b>
<b>NON-CASH BENEFITS [Head of Household and Adults only]</b>		
<b>Currently receiving Non-Cash Benefits?</b> <i>Is the client currently receiving one of the non-cash benefits listed below?</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
<b>If Yes, indicate all the non-cash benefits the client is receiving:</b>		<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP)/Cal Fresh

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

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

*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.*

*DO NOT include benefits received by other adults (18 years and older) in the household; record their benefits on their Enrollment form.*

- ☐ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- ☐ TANF/CALWORKS Childcare Services
- ☐ TANF/CALWORKS Transportation Services
- ☐ Other TANF/CALWORKS-Funded Services
- ☐ Other Non-Cash Benefit

If Other Specify: \_\_\_\_\_

## HEALTH INSURANCE

### Currently covered by health insurance?

*Is the client currently covered by health insurance?*

- ☐ Yes   ☐ No   ☐ Client doesn't know   ☐ Client prefers not to answer
- ☐ Data Not Collected

### If Yes, type(s) of insurance(s):

*If the client is currently covered by multiple health insurances please select all that apply.*

- ☐ Medicaid (same as Medi-Cal)
- ☐ Medicare
- ☐ State Children's Health Insurance (CHIP) Program
- ☐ Veteran's Health Administration (VHA)
- ☐ Employer-Provided Health Insurance
- ☐ Health Insurance Obtained Through COBRA
- ☐ Private Pay Health Insurance
- ☐ State Health Insurance for Adults
- ☐ Indian Health Services Program
- ☐ Other Health Insurance

If Other Specify: \_\_\_\_\_

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

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