Marin County Continuum of Care

Standard HMIS Child Client Status Update and/or Annual Assessment

Program Name: _____ Case Worker/Intake Person: _____ Date: _____

CLIENT STATUS UPDATE/ANNUAL ASSESSMENT

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

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

Separate client Status Update and/or Annual Assessments should be completed for each child client *as long as they are not the Head of Household.* **A separate Status Update and/or Annual Assessment form must be completed for adult household members, but please be sure to use the Standard Adult Client Status Update and/or Annual Assessment form.**

1) Client Name	**First**	**Last**
2) Project Status Update or Annual Assessment Date	☐☐/☐☐/☐☐☐☐ Month Day Year	

DISABLING CONDITIONS: A Disabling Condition is a health condition that interferes with getting and/or keeping stable housing.

1) Does the client have a Physical Disability?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer ❑ 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?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected
2) Does the client have a Developmental Disability?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected
3) Does the client have a Chronic Health Condition?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer ❑ 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?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected

Client Name_____

Head of Household Name (if not Self) _____

4) Does the client have HIV – AIDS?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected
5) Does the client have a Mental Health Disorder?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer ❑ 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?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected
6) Does the client have any Substance Use Disorder?	❑ No ❑ Alcohol use disorder ❑ Drug use disorder ❑ Both Alcohol & Drug Abuse Use Disorders	❑ Client doesn't know ❑ Client prefers not to answer ❑ 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?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer ❑ Data Not Collected

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) _____