



A Tradition of Stewardship
A Commitment to Service

Napa 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.

Separate Status Update and/or Annual Assessments should be completed for each client who is **over** the age of 17 or the Head of Household. **Status Update and/or Annual Assessments must be completed for children as well, but please be sure to use the Standard HMIS Child Status Update and/or Annual Assessment Form.**

1) Client Name	First	Last																				
2) Project Status Update or Annual Assessment Date	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;">/</td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;">/</td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td> </tr> <tr> <td>Month</td><td>Day</td><td></td><td>Year</td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>				/			/					Month	Day		Year						
		/			/																	
Month	Day		Year																			
3) Housing Move-in Date [Head of Household only] <i>(Required for Permanent Housing Projects only)</i> IMPORTANT REMINDER: 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" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;">/</td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;">/</td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td> </tr> <tr> <td>Month</td><td>Day</td><td></td><td>Year</td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>				/			/					Month	Day		Year						
		/			/																	
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? 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
	<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
2) Does the client have a Developmental Disability?	<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

Client Name _____

Head of Household Name (if not Self) _____

<p>3) Does the client have a Chronic Health Condition?</p>	<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
<p>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</p>	<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
<p>4) Does the client have HIV – AIDS?</p>	<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
<p>5) Does the client have a Mental Health Disorder?</p>	<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
<p>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</p>	<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
<p>6) Does the client have any Substance Use Disorder?</p>	<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
<p>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</p>	<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]

<p>1) Survivor of Domestic Violence</p> <p><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>If the answer is "no", skip to "Monthly Income – Cash Benefits" section.</p> <p>If the answer is "yes", COMPLETE questions 2 and 3.</p>	<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
<p>2) Most Recent Occurrence</p> <p><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>	<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 <input type="checkbox"/> Data Not Collected

Client Name _____

Head of Household Name (if not Self) _____

<p>3) Current Status <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>	<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
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MONTHLY INCOME – CASH BENEFITS [Head of Household and Adults only]

<p>Current income from any source? <i>Is the client currently receiving any income from any source?</i></p>	<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
<p>Specify the type(s) and amount(s) of income the client currently receives. <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></p>	<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: _____
<p>Total Monthly Cash Income for Individual</p>	<p>TOTAL: \$ _____</p>

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

<p>Currently receiving Non-Cash Benefits? <i>Is the client currently receiving one of the non-cash benefits listed below?</i></p>	<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
<p>If Yes, indicate all the non-cash benefits the client is receiving:</p>	<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP)/Cal Fresh <input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

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.

- 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) _____