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**

CLIENT LOCATION *[only if multiple CoC's]* _____

DISABLING CONDITION *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected

PHYSICAL DISABILITY *[All Clients]*

○	No			○	Client doesn't know
○	Yes			○	Client refused
				○	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?	○	No	○	Client doesn't know
	○	Yes	○	Client refused
			○	Data not collected

DEVELOPMENTAL DISABILITY *[All Clients]*

○	No			○	Client doesn't know
○	Yes			○	Client refused
				○	Data not collected
IF "YES" TO DEVELOPMENTAL DISABILITY – SPECIFY					
Expected to substantially impair ability to live independently?	○	No	○	Client doesn't know
	○	Yes	○	Client refused
			○	Data not collected

CHRONIC HEALTH CONDITION *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	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?	○	No	○	Client doesn't know
	○	Yes	○	Client refused
			○	Data not collected

HIV-AIDS *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected

IF "YES" TO HIV-AIDS – SPECIFY

Expected to substantially impair ability to live independently?	○	No	○	Client doesn't know
	○	Yes	○	Client refused
			○	Data not collected

MENTAL HEALTH PROBLEM *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected

IF "YES" TO MENTAL HEALTH CONDITION – SPECIFY

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

SUBSTANCE ABUSE PROBLEM *[All Clients]*

○	No	○	Both alcohol and drug abuse
○	Alcohol abuse	○	Client doesn't know
		○	Client refused
○	Drug abuse	○	Data not collected

IF "ALCOHOL ABUSE" "DRUG ABUSE" OR "BOTH ALCOHOL AND DRUG ABUSE" – SPECIFY

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

INCOME FROM ANY SOURCE *[Head of Household and Adults]*

○	No		○	Client doesn't know
○	Yes		○	Client refused
			○	Data not collected

IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY

	Income Source	Amount		Income Source	Amount
○	Alimony and other spousal support		○	Child support	
○	Pension or retirement income from former job		○	Earned Income	
○	Retirement Income from Social Security		○	CAAP	
○	Social Security Disability Insurance (SSDI)		○	Private disability insurance	
○	Supplemental Security Income (SSI)		○	Unemployment Insurance	
○	CalWORKs		○	Worker's Compensation	
○	VA Service Connected Disability Compensation		○	Other source	
○	VA Non--Service Connected Disability Pension		Other (specify):	
Total monthly amount:					

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

○	No		○	Client doesn't know
○	Yes		○	Client refused
			○	Data not collected

IF "YES" TO NON-CASH BENEFITS – INDICATE ALL SOURCES THAT APPLY

○	CalFresh		○	CalWORKs Childcare Services
○	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)		○	CalWORKs Transportation Services
○	Other (specify):		○	Other CalWORKs-funded services

COVERED BY HEALTH INSURANCE *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected

IF "YES" TO HEALTH INSURANCE - HEALTH INSURANCE COVERAGE DETAILS

○	Medi-Cal	○	Employer Provided Health Insurance
○	MEDICARE	○	Insurance Obtained through COBRA
○	State Children's Health Insurance (SCHIP)	○	Private Pay Health Insurance
○	Veteran's Administration (VA) Medical Services	○	State Health Insurance for Adults
○	Other (specify):	○	Indian Health Services Program

RHY SPECIFIC YOUTH INFORMATION

PREGNANCY STATUS *[All Female: HoH, Adults and Unaccompanied Youth]*

○	No	o	Client doesn't know
○	Yes	o	Client refused
		o	Data not collected

IF "YES" for Pregnancy Status	
Due Date	____/____/_____

_____

Signature of applicant stating all information is true and correct   Date