HMIS #	______________________
Client Name	______________________
Staff Name	______________________
Date	______________________

Santa Cruz County HMIS – HOPWA Adult Status Update and/or Annual Assessment

A service provider must complete a HOPWA Adult Status Update Assessment every 90 days an adult client or the Head of Household has been enrolled in a HOPWA-funded program, regardless of whether their information has changed. After the client has been enrolled in the program for 1 year, the service provider must complete a HOPWA Adult Annual Assessment in lieu of a Status Assessment. This form can be used for either the Status Assessment or Annual Assessment because the same information is collected, however, please be sure to select the appropriate Assessment type when entering this data into the HMIS. Separate HOPWA 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 HOPWA Child Status Update and/or Annual Assessment Form.**

Project Status Update Date

		/			/				

Month Day Year

Disabling Conditions (All Responses required)

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

Question		
1) Does the client have a Physical Disability?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer
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
2) Does the client have a Developmental Disability?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer
3) Does the client have a Chronic Health Condition?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer
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
4) Does the client have HIV – AIDS? *If **Yes**, please be sure to answer the required HIV/AIDS questions below.*	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer

Client Name ______________________________

Head of Household Name (if not Self) ______________________________

5) Does the client have a Mental Health Disorder?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer
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
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
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

Domestic Violence [Head of Household and Adults]

1) Survivor of Domestic Violence *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?"* ***If the answer is "no", skip to "Monthly Income – Cash Benefits" section.*** ***If the answer is "yes", COMPLETE questions 2 and 3.***	❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer	
2) Most Recent Occurrence *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?"*	❑ Within the past three months ❑ Three to six months ago (excluding six months exactly) ❑ Six months to one year ago (excluding one year exactly) ❑ One year ago or more ❑ Client doesn't know ❑ Client prefers not to answer	
3) Current Status *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?"*	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer

Client Name ______________________________

Head of Household Name (if not Self) ______________________________

Monthly Income – Cash Benefits [Head of Household and Adults]

Current income from any source? *Is the client currently receiving any income from any source?*	❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer
Specify the type(s) and amount(s) of income the client currently receives. *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.* *DO NOT include income received by other adults (18 years and older) in the household; record their income on their Enrollment form.*	❑ Earned Income $____________ ❑ Unemployment Insurance $___________ ❑ Supplemental Security Income SSI $___________ ❑ Social Security Disability Insurance SSDI $_____________ ❑ VA Service-Connected Disability Pension$_____________ ❑ VA Non-service connect disability pension $____________ ❑ Private Disability Insurance $__________ ❑ Worker's Compensation $_____________ ❑ Temporary Assistance for Needy Families TANF/CalWORKs $___________ ❑ General Assistance (GA) $____________ ❑ Retirement income from Social Security $______________ ❑ Pension or Retirement Income from a Former Job $______________ ❑ Child Support $_____________ ❑ Alimony and Other Spousal Support $__________ ❑ Other Cash Income $_________ If Other Specify: ______________________________
Total Cash Income for Individual	**TOTAL**: $_______________

Non-Cash Benefits [Head of Household and Adults]

Currently receiving Non-Cash Benefits? *Is the client currently receiving one of the non-cash benefits listed below?*	❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer
If Yes, indicate all the non-cash benefits the client is receiving: *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.*	❑ Supplemental Nutrition Assistance Program (SNAP)/Cal Fresh ❑ 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: ______________________________

Client Name ______________________________________

Head of Household Name (if not Self) ______________________________________

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
If Yes, type(s) of insurance(s) and reason(s) not covered: *If the client is currently covered by multiple health insurances please select all that apply.*	❑ Medicaid (same as Medi-Cal) ❑ Applied; Decision Pending ❑ Applied; Client Not Eligible ❑ Client Did Not Apply ❑ Insurance Type N/A for this Client ❑ Client doesn't know ❑ Client prefers not to answer
	❑ Medicare ❑ Applied; Decision Pending ❑ Applied; Client Not Eligible ❑ Client Did Not Apply ❑ Insurance Type N/A for this Client ❑ Client doesn't know ❑ Client prefers not to answer
	❑ State Children's Health Insurance (CHIP) Program ❑ Applied; Decision Pending ❑ Applied; Client Not Eligible ❑ Client Did Not Apply ❑ Insurance Type N/A for this Client ❑ Client doesn't know ❑ Client prefers not to answer
	❑ Veteran's Health Administration (VHA) ❑ Applied; Decision Pending ❑ Applied; Client Not Eligible ❑ Client Did Not Apply ❑ Insurance Type N/A for this Client ❑ Client doesn't know ❑ Client prefers not to answer
	❑ Employer-Provided Health Insurance ❑ Applied; Decision Pending ❑ Applied; Client Not Eligible ❑ Client Did Not Apply ❑ Insurance Type N/A for this Client ❑ Client doesn't know ❑ Client prefers not to answer

	❑ Health Insurance Obtained Through COBRA ❑ Applied; Decision Pending ❑ Applied; Client Not Eligible ❑ Client Did Not Apply ❑ Insurance Type N/A for this Client ❑ Client doesn't know ❑ Client prefers not to answer
	❑ Private Pay Health Insurance ❑ Applied; Decision Pending ❑ Applied; Client Not Eligible ❑ Client Did Not Apply ❑ Insurance Type N/A for this Client ❑ Client doesn't know ❑ Client prefers not to answer
	❑ State Health Insurance for Adults ❑ Applied; Decision Pending ❑ Applied; Client Not Eligible ❑ Client Did Not Apply ❑ Insurance Type N/A for this Client ❑ Client doesn't know ❑ Client prefers not to answer
	❑ Indian Health Services Program ❑ Applied; Decision Pending ❑ Applied; Client Not Eligible ❑ Client Did Not Apply ❑ Insurance Type N/A for this Client ❑ Client doesn't know ❑ Client prefers not to answer
	❑ Other Health Insurance If Other Specify: ____________________________

Medical Assistance [All Household Members with HIV/AIDS]

Is the client receiving AIDS Drug Assistance Program (ADAP)?	❑ No ❑ Yes ❑ Client doesn't know ❑ Client prefers not to answer
If No for "Receiving AIDS Drug Assistance Program (ADAP)," please select the appropriate reason:	❑ Applied; decision pending ❑ Applied; client not eligible ❑ Client did not apply ❑ Insurance type N/A for this client ❑ Client doesn't know ❑ Client prefers not to answer

Client Name ____

Head of Household Name (if not Self) ____

Is the client receiving AIDS Drug Assistance Program (ADAP)?	❑ No ❑ Yes ❑ Client doesn't know ❑ Client prefers not to answer
If No for "Receiving AIDS Drug Assistance Program (ADAP)," please select the appropriate reason:	❑ Applied; decision pending ❑ Applied; client not eligible ❑ Client did not apply ❑ Insurance type N/A for this client ❑ Client doesn't know ❑ Client prefers not to answer

T-cell (CD4) and Viral Load [All Household Members with HIV/AIDS]

T-Cell (CD4) Count Available?	❑ No ❑ Yes ❑ Client doesn't know ❑ Client prefers not to answer
If Yes to "T-Cell (CD4) Count Available," then please collect the T-cell Count number: *Integer between 0-1500*	
If a number is entered in the T-Cell (CD4) count, then how was the information obtained?	❑ Medical Report ❑ Client Report ❑ Other
Viral Load Information Available?	❑ Not Available ❑ Available ❑ Undetectable ❑ Client doesn't know ❑ Client prefers not to answer
If "Viral Load Information Available," then please collect the Viral Load Count: *Integer between 0-999999*	
If a number is entered in the Viral Load count, then how was the information obtained?	❑ Medical Report ❑ Client Report ❑ Other

Prescribed Anti-Retroviral [All Household Members with HIV/AIDS]

Has the participant been prescribed anti-retroviral drugs?	❑ No ❑ Yes ❑ Client doesn't know ❑ Client prefers not to answer

Reminder: Housing Move-in Date [Head of Household]

(***Required for Permanent Housing Projects***)

IMPORTANT REMINDER: If the client moved 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 with the date the client/household moved into the permanent unit.**

Client Name ____________________

Head of Household Name (if not Self) ____________________