

HMIS # _____
Client Name _____
Staff Name _____
Date _____

## Santa Cruz County HMIS – Standard Child Status and/or Annual Assessment

A service provider must complete a Standard Child Status Assessment every 90 days a child client has been enrolled in a specific 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 Standard 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 Status Update and/or Annual Assessments should be completed for each client who is **under** the age of 18 *unless they are the Head of Household*. **Status Update and/or Annual Assessments must be completed for adults as well, but please be sure to use the Standard HMIS Adult 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.

<p><b>1) Does the client have a Physical Disability?</b></p> <p><i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i></p>	<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"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
<p><b>2) Does the client have a Developmental Disability?</b></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
<p><b>3) Does the client have a Chronic Health Condition?</b></p> <p><i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i></p>	<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"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
<p><b>4) Does the client have HIV – AIDS?</b></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
<p><b>5) Does the client have a Mental Health Disorder?</b></p> <p><i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i></p>	<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"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer

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

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

<p><b>6) Does the client have a Substance Use Disorder?</b></p> <p><i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i></p>	<input type="checkbox"/> No <input type="checkbox"/> Alcohol use disorder <input type="checkbox"/> Drug use disorder <input type="checkbox"/> Both Alcohol & Drug use disorders	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer

**Health Insurance**

<p><b>Currently covered by health insurance?</b>  <i>Is the client currently covered by health insurance?</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
<p><b>If Yes, type(s) of insurance(s)</b>  <i>If the client is currently covered by multiple health insurances please select all that apply.</i></p>	<input type="checkbox"/> Medicaid (same as Medi-Cal) <input type="checkbox"/> Medicare <input type="checkbox"/> State Children's Health Insurance (CHIP) Program <input type="checkbox"/> Veteran's Health Administration (VHA) <input type="checkbox"/> Employer-Provided Health Insurance <input type="checkbox"/> Health Insurance Obtained Through COBRA <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Other Health Insurance If Other Specify: _____

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