MSHMIS SSVF Update

Review Date: ___________________ **Client Location (CoC Code) for HoH**: ___________ **Review Type: ☐ Routine.☐ 30 day ☐ 60 day ☐ 90 day ☐ 120 day ☐ 180 day ☐ Annual**

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Please Update Any Responses that Have Changed Since Entry/Last Review

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Answer this section for all persons in household (use additional sheets for larger families)

Name & Client ID *(Answer for All Persons in HH)*	**Housing Status**	**General Health Status**	**Currently Covered by Health Insurance?**	***(If Client has Health Insurance)*** **Select All Type(s) That Apply**
	☐ Cat 1-Homeless ☐ Cat 2-Imminent Risk of losing housing ☐ Cat 3-Homeless under other Fed Statutes ☐ Cat 4-Fleeing domestic violence ☐ At risk of homelessness ☐ Stably Housed ☐ Client doesn't know ☐ Client refused	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ MEDICAID ☐ MEDICARE ☐ State Children's Health Insurance Program ☐ Veteran Administration (VA) Medical Services ☐ Employer Provided Health Insurance ☐ Health Insurance Obtained through COBRA ☐ Private Pay Health Insurance ☐ State Health Insurance for Adults ☐ Indian Health Services Program ☐ Other (If Other Specify)_________________
	☐ Cat 1-Homeless ☐ Cat 2-Imminent Risk of losing housing ☐ Cat 3-Homeless under other Fed Statutes ☐ Cat 4-Fleeing domestic violence ☐ At risk of homelessness ☐ Stably Housed ☐ Client doesn't know ☐ Client refused	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ MEDICAID ☐ MEDICARE ☐ State Children's Health Insurance Program ☐ Veteran Administration (VA) Medical Services ☐ Employer Provided Health Insurance ☐ Health Insurance Obtained through COBRA ☐ Private Pay Health Insurance ☐ State Health Insurance for Adults ☐ Indian Health Services Program ☐ Other (If Other Specify)_________________
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	☐ Cat 1-Homeless ☐ Cat 2-Imminent Risk ☐ Cat 3-Other Fed Statutes ☐ Cat 4-Fleeing ☐ At Risk of Homelessness ☐ Stably Housed ☐ Client doesn't know ☐ Client refused	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ MEDICAID ☐ MEDICARE ☐ State Children's Health Insurance Program ☐ Veteran Administration (VA) Medical Services ☐ Employer Provided Health Insurance ☐ Health Insurance Obtained through COBRA ☐ Private Pay Health Insurance ☐ State Health Insurance for Adults ☐ Indian Health Services Program ☐ Other (If Other Specify)_________________

Answer this section for all persons in household (use additional sheets for larger families)

Name *(Please Answer for All Persons in HH)*	**Does the client have a disabling condition?**	**If client has a disabling condition, please answer the following sub-assessment questions:**					
		Disability Type (Select all that apply)	*Disability Determination*	*If Yes, to be long-continued and indefinite duration and substantially impairs ability to live independently?*	*Documentation of Disability and Severity on File*	*Currently Receiving Services/ Treatment for this disability*	*Long Term*
Person 1 (head of household):	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Physical ☐ Developmental ☐ Chronic Health Condition ☐ HIV/AIDS ☐ Mental Health Problems ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol & Drug Abuse	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No
Person 2:	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Physical ☐ Developmental ☐ Chronic Health Condition ☐ HIV/AIDS ☐ Mental Health Problems ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol & Drug Abuse	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No
Person 3:	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Physical ☐ Developmental ☐ Chronic Health Condition ☐ HIV/AIDS ☐ Mental Health Problems ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol & Drug Abuse	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No
Person 4:	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Physical ☐ Developmental ☐ Chronic Health Condition ☐ HIV/AIDS ☐ Mental Health Problems ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol & Drug Abuse	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No

INCOME & NON-CASH BENEFITS

****Answer for ALL Household Members****

Currently receiving income from any source? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

X	Source of Income (Monthly)	Family Member	Amount from Source
	Alimony or Other Spousal Support		$ .00
	Child Support		$ .00
	Earned Income (*Employment*)		$ .00
	Pension or Retirement Income From a Former Job		$ .00
	Private Disability Insurance		$ .00
	Retirement Income from Social Security		$ .00
	SSDI *(Social Security Disability Income)*		$ .00
	SSI (*Supplemental Security Income*)		$ .00
	TANF *(Temporary Assistance for Needy Families or FIP) grant*)		$ .00
	Unemployment Insurance		$ .00
	VA Service-Connected Disability Compensation		$ .00
	VA Non-Service-Connected Disability Pension		$ .00
	Workers Compensation		$ .00
	General Assistance		$ .00
	Other *(Including Gifts from Friends and Family)*		$ .00
	No Financial Resources		$ .00
	Total Monthly Income Reported		$ .00

(If Other Source), **Specify**_____ **Total Monthly Income (per household member)** $_____

Currently receiving any non-cash benefits? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

X	Source of Non-Cash Benefit (Monthly)	Family Member	Amount (if applicable)
	Supplemental Nutrition Assistance Program *(Food Stamps*)		$ .00
	Special Supplemental Nutrition Program for WIC		$ .00
	TANF Child Care Services		$ .00
	TANF Transportation Services		$ .00
	Other TANF Funded-Services		$ .00
	Section 8, Public Housing or rental assistance		$ .00
	Other Source		$ .00
	Temporary Rental Assistance		$ .00

(If Other Source), **Specify**_____

*****Answer the following questions for HEAD OF HOUSEHOLD and ADULTS only! (Print additional pages where needed) *****

DOMESTIC VIOLENCE

*Domestic Violence Victim/Survivor should be indicated as **"Yes"** if the person has experienced any domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has taken place **within the individual's or family's primary nighttime residence.***

Domestic Violence Victim/Survivor? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

***(If yes)* When Experience Occurred**

☐ 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 refused

*Currently fleeing should be indicated as **"Yes"** if the Person is fleeing, or is attempting to flee, the domestic violence situation **or** is afraid to return to their primary nighttime residence.*

***(If yes)* Are you currently fleeing?** ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

Overview of domestic violence: _____

RESIDENTIAL MOVE-IN DATE

****Answer the following questions for ALL Household Members****

Date of Move-In_____ ***IMPORTANT: Not same as the Move-In date listed on the VA HOMES System*

CONTACT INFORMATION

Client's Cell Phone Number:

_____

Emergency Contact's Name: _____

Contact Type (Relationship to Client): _____

Phone Number: _____

Second Phone Number: _____

Contact's E-mail Address: _____

Contact's Street Address: _____

Contact's City: _____ **State:** _____ **Zip Code:** _____

Emergency Contact's Name: _____

Contact Type (Relationship to Client): _____

Phone Number: _____

Second Phone Number: _____

Contact's E-mail Address: _____

Contact's Street Address: _____

Contact's City: _____ **State:** _____ **Zip Code**_____