MSHMIS Update

Review Date: _______________ **Review Type: (30 day, 60 day, annual, etc.) _________________**

****

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

****

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

Name & Client ID *(Please Answer for All Persons in HH)*	**Active Duty US Military Veteran**	**Currently Covered by Health Insurance?**	***(If Client has Health Insurance)*** **Select All Type(s) That Apply**	**In Permanent Housing? (RRH ONLY)**	**Pregnant?**
	(Answer for adults 18+ only) ☐ Yes ☐ No ☐ 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)_________________	**Residential Move-In Date:** _____/______/_____ *For clients who have moved into permanent housing via the Rapid-Rehousing project.*	☐ Yes ☐ No *(If Yes)* Projected Date of Birth ________
	(Answer for adults 18+ only) ☐ Yes ☐ No ☐ 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)_________________	**Residential Move-In Date:** _____/______/_____ *For clients who have moved into permanent housing via the Rapid-Rehousing project.*	☐ Yes ☐ No *(If Yes)* Projected Date of Birth ________
	(Answer for adults 18+ only) ☐ Yes ☐ No ☐ 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)_________________	**Residential Move-In Date:** _____/______/_____ *For clients who have moved into permanent housing via the Rapid-Rehousing project.*	☐ Yes ☐ No *(If Yes)* Projected Date of Birth ________

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 (Yes/No)*
	☐ 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 ☐ 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 ☐ 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	

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

Income and Non-Cash Benefit Information

Total Monthly Income (per household member) $_____

Currently receiving income from any source? □ Yes □ No □ Client doesn't know □ Client refused
(If Yes, complete sub-assessment)

MONTHLY INCOME sub-assessment

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** _____

Currently receiving any non-cash benefits? □ Yes □ No □ Client doesn't know □ Client refused
(If Yes, complete sub-assessment)

NON-CASH BENEFIT sub-assessment

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**_____

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

_____

Additional Updates

Connection With SOAR?

- ☐ Yes
- ☐ No
- ☐ Client doesn't know
- ☐ Client refused

Client Location *(CoC Code):* _____ **(Answer for Head of Household Only)**

Assessment Disposition –

Required for Coordinated Assessment Only
Answer for Head of Household Only

- □ Referred to emergency shelter/safe haven
- □ Referred to transitional housing
- □ Referred to rapid re-housing
- □ Referred to permanent supportive housing
- □ Referred to homeless outreach
- □ Referred to street outreach
- □ Referred to other continuum project type
- □ Referred to a homelessness diversion program
- □ Unable to refer/accept within continuum; ineligible for continuum projects
- □ Unable to refer/accept within continuum; continuum services unavailable
- □ Referred to other community project (non-continuum)
- □ Applicant denied referral/acceptance
- □ Applicant terminated assessment prior to completion
- □ Other/specify

Contact Information

Client Location *(CoC Code):* _____ **(Answer for Head of Household Only)**

Client's Cell Phone Number _____

Emergency Contact's Name _____

Contact Type (Relationship to Client) _____

Phone Number _____

Second Phone Number _____

Email Address _____

Contact's Address: Street _____ **City** _____ **State** _____

Contact's Zip Code _____

CONTACTS & ENGAGEMENT

(REQUIRED FOR ALL STREET OUTREACH AND NBN SHELTERS)

Street Outreach Projects and **Emergency Shelters using the Night-by-Night Method of Tracking** MUST record the date and location of **EACH CONTACT** made with clients including the **'Date of Engagement**'.

Please see the *HMIS Data Collection – Street Outreach Supplemental Form* and *2014 HUD Data Standards* for more information.