NC HMIS SSVF Update

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

****

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 *(Answer for All Persons in HH)*	**Does the client have a disabling condition?**	*Disability Type (Select all that apply)*	*If Yes, to be long-continued and indefinite duration and substantially impairs ability to live independently?*	**Currently Covered by Health Insurance?**	***(If Client has Health Insurance)*** **Select All Type(s) That Apply**
	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Physical ☐ Developmental ☐ Chronic Health Condition ☐ HIV/AIDS ☐ Mental Health Problem ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol & Drug Abuse	☐ 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)________________
	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Physical ☐ Developmental ☐ Chronic Health Condition ☐ HIV/AIDS ☐ Mental Health Problem ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol & Drug Abuse	☐ 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)________________
	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Physical ☐ Developmental ☐ Chronic Health Condition ☐ HIV/AIDS ☐ Mental Health Problem ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol & Drug Abuse	☐ 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)________________
	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Physical ☐ Developmental ☐ Chronic Health Condition ☐ HIV/AIDS ☐ Mental Health Problem ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol & Drug Abuse	☐ 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)________________

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

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 Insurance)*		$ .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 (SNAP) *(previous known as Food Stamps)*		$ .00
	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)		$ .00
	TANF Child Care Services		$ .00
	TANF Transportation Services		$ .00
	Other TANF Funded-Services		$ .00
	Other Source- **Specify**:		$ .00

RESIDENCE AND SERVICE

City of Residence _____ County of *Residence*_____ County of *Service*_____

CONNECTION WITH SOAR

☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused

ADULT CARE HOME **for HEAD OF HOUSEHOLD and ADULTS (18+) only!**

Has Client Lived in an Adult Care Home in 2012? ☐ No ☐ Yes ☐ Client doesn't know ☐ Client refused

(If Yes) Adult Care Home Client Lived In Most Recently: _____

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 Cod**

HOUSING MOVE-IN DATE **Answer for the Head of Household**
For RAPID REHOUSING only!

*This question differentiates between clients who are awaiting placement and those who have moved into any type of permanent housing, regardless of funding source or whether the project is providing rental assistance. The Housing Move-In Date MUST be entered via an **Interim Assessment** with a timestamp that occurs after the Project Start and before the Project Exit. If client is **not** in housing leave this question blank.*

Housing Move-In Date: _____/_____/_____