

# NC HMIS Update

Review Date: \_\_\_\_\_

Review Type: (30 day, 60 day, annual, etc.) \_\_\_\_\_

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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 <i>(Please Answer for All Persons in HH)</i>	Currently Covered by Health Insurance?	<i>(If Client has Health Insurance)</i> Select All Type(s) That Apply
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Veteran Administration (VA) Medical Services <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 (If Other Specify)_____
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Veteran Administration (VA) Medical Services <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 (If Other Specify)_____
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Veteran Administration (VA) Medical Services <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 (If Other Specify)_____

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

Name <i>(Please Answer for All Persons in HH)</i>	Does the client have a disabling condition?	If client has a disabling condition, please answer the following sub-assessment questions:			
		Disability Type <i>(Select all that apply)</i>	Disability Determination	If Yes, to be long-continued and indefinite duration and substantially impairs ability to live independently?	Long Term <i>(Yes/No)</i>
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problems <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problems <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problems <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> 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 ( <i>Employment</i> )		\$ .00
	General Assistance		\$ .00
	Pension or Retirement Income from a Former Job		\$ .00
	Private Disability Insurance		\$ .00
	Retirement Income from Social Security		\$ .00
	SSDI ( <i>Social Security Disability Insurance</i> )		\$ .00
	SSI ( <i>Supplemental Security Income</i> )		\$ .00
	TANF ( <i>Temporary Assistance for Needy Families or FIP grant</i> )		\$ .00
	Unemployment Insurance		\$ .00
	VA Service-Connected Disability Compensation		\$ .00
	VA Non-Service-Connected Disability Pension		\$ .00
	Workers Compensation		\$ .00
	Other ( <i>Including Gifts from Friends and Family</i> )		\$ .00
	<b>No Financial Resources</b>		\$ .00
	<b>Total Monthly Income Reported</b>		\$ .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 ( <i>Food Stamps</i> )		\$ .00
	Special Supplemental Nutrition Program for WIC		\$ .00
	TANF Child Care Services		\$ .00
	TANF Transportation Services		\$ .00
	Other TANF Funded-Services		\$ .00
	Other Source		\$ .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?

- |                              |  |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> No  | <input type="checkbox"/> Client refused      |

### (If yes) When Experience Occurred

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Within the past three months                           | <input type="checkbox"/> Six months to one year ago (excluding one year exactly) | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Three to six months ago (excluding six months exactly) | <input type="checkbox"/> One year ago or more                                    | <input type="checkbox"/> 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?

- |                              |  |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> No  | <input type="checkbox"/> Client refused      |

### Overview of domestic violence

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### Housing Move-In Date

**(Required for all PH and RRH Projects - For clients who have moved into permanent housing via the Rapid-Rehousing project and Permanent Housing projects; this field is required for the Head of Household 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Additional Updates

Client Location (CoC Code): \_\_\_\_\_ (Answer for Head of Household Only)

### Connection With SOAR?

- Yes  
 No

- Client doesn't know  
 Client refused

## Contact Information

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 if the client is staying on the streets, ES or SH of **EACH CONTACT** made with clients including the '**Date of Engagement**'.

Please see the *HMIS Data Collection – Street Outreach Supplemental Form* and *2017 HUD Data Standards* for more information