

NC HMIS VA-GPD 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 <i>(Answer for All Persons in HH)</i>	Does the client have a disabling condition?	Disability Type <i>(Select all that apply)</i>	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
	<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 Problem <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"/> 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"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problem <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"/> 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) _____
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	<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 Problem <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"/> 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 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: _____

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 Code

HOUSING MOVE-IN DATE **** Answer for the Head of Household**** **For PH 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: ____/____/____