NC HMIS VASH 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		$ .00

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

RESIDENCE AND SERVICE

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

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: _____

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: _____/_____/_____

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: _____

PLEASE ANSWER THE QUESTIONS IN THIS BOX FOR HUD/VASH-OTH PROGRAMS ONLY

Answer for HEAD OF HOUSEHOLD and ADULTS (18+) only!

HUD VASH VOUCHER TRACKING

Voucher Change*:*

☐ Referral package forwarded to PHA
☐ Voucher denied by PHA
☐ Voucher issued by PHA
☐ Voucher revoked or expired
☐ Voucher in use-veteran moved into housing
☐ Voucher was ported locally

Information Date: _____

☐ Voucher was administratively absorbed by new PHA
☐ Voucher converted to Housing Choice Voucher
☐ Veteran exited—voucher was returned
☐ Veteran exited-family maintained the voucher
☐ Veteran exited-prior to ever receiving a voucher
☐ Other