

NC HMIS 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 <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	Housing Move In Date
	<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) _____	Housing Move-In Date: ____/____/____ <i>For clients who have moved into permanent housing via the Rapid-Rehousing project and Permanent Housing projects</i>
	<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) _____	Housing Move-In Date: ____/____/____ <i>For clients who have moved into permanent housing via the Rapid-Rehousing project and Permanent Housing projects</i>
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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
	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 (<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

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