

HMIS Standard Update Form for HOPWA – ES (Hotel/Motel) projects

Effective 10/01/2023

Intake Date

		/			/		
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Entry Date

		/			/		
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ServicePoint

(HoH) ID:

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Project Name

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HoH First Name

Middle

--	--

Last

Suffix

Alias

--	--	--

Full Name Reported

Partial, Street or Code Name

Client doesn't know

Client prefers not to answer

Social Security Number:

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Full SSN reported

Approx or Partial SSN

Client doesn't know

Client prefers not to answer

Date of Birth:

		/			/		
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Full DOB reported

Approx or Partial DOB

Client doesn't know

Client prefers not to answer

Race and Ethnicity (Select all that apply)

American Indian, Alaska Native, or Indigenous

Native Hawaiian or Pacific Islander

Asian or Asian American

White

Black, African American, or African

Client doesn't know

Hispanic/Latina/e/o

Client prefers not to answer

Middle Eastern or North African

Additional Race and Ethnicity detail: _____

Gender (Select all that apply)

Woman (Girl, if child)

Questioning

Man (Boy, if child)

Different Identity

Culturally Specific Identity (e.g., Two-Spirit)

Client doesn't know

Transgender

Client prefers not to answer

Non-Binary

If Different Identity, Please Specify: _____

Veteran Status

No

Yes

Relationship to Head of Household (Must be an adult)

Self (Head of Household)

HoH's child

HoH's spouse or partner

HoH's other relation member

Other: non-relation member

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Health Insurance	
<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Yes (identify source below)	<input type="checkbox"/> Client prefers not to answer
Source	
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare
<input type="checkbox"/> State Children's Health Insurance (KCHIP)	<input type="checkbox"/> Veteran's Health Administration (VHA)
<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: _____

Disability						
Do you have a physical, mental or emotional impairment, a post-traumatic stress disorder, or brain injury; a development disability, HIV/AIDS, or a diagnosable substance abuse problem?						
<input type="checkbox"/> No <input type="checkbox"/> Yes (indicate type(s) below) <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer						
	Physical <input type="checkbox"/>	Mental Health <input type="checkbox"/>	Chronic Health Condition <input type="checkbox"/>	<input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs <input type="checkbox"/> Both	Developmental <input type="checkbox"/>	HIV/AIDS <input type="checkbox"/>
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>



****IF CLIENT IS A MINOR WHO IS NOT HEAD OF HOUSEHOLD STOP DATA ENTRY HERE****

Income	
<input type="checkbox"/> No/None at all	<input type="checkbox"/> Yes (identify source and amounts)
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
Source	Amount:
<input type="checkbox"/> Earned income (i.e., employment income)	\$ _____ .00
<input type="checkbox"/> Unemployment Insurance	\$ _____ .00
<input type="checkbox"/> Supplemental Security Income (SSI)	\$ _____ .00
<input type="checkbox"/> Social Security Disability Income (SSDI)	\$ _____ .00
<input type="checkbox"/> Retirement Income from Social Security	\$ _____ .00
<input type="checkbox"/> VA Service-Connected Disability Compensation	\$ _____ .00
<input type="checkbox"/> VA Non-Service-Connected Disability Pension	\$ _____ .00
<input type="checkbox"/> Worker's Compensation	\$ _____ .00
<input type="checkbox"/> Temporary Assistance for Needy Families (TANF)	\$ _____ .00
<input type="checkbox"/> General Assistance (GA)	\$ _____ .00
<input type="checkbox"/> Private disability Insurance	\$ _____ .00
<input type="checkbox"/> Pension or retirement income from a former job	\$ _____ .00
<input type="checkbox"/> Child Support	\$ _____ .00
<input type="checkbox"/> Alimony or other spousal support	\$ _____ .00
<input type="checkbox"/> Other source: _____	\$ _____ .00
Total Monthly Income:	\$ _____

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Non-Cash Benefits	
<input type="checkbox"/> No/None at all	<input type="checkbox"/> Yes (Identify source below)
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
Source	
<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) <input type="checkbox"/> Special Supplemental, Nutrition Program for Women, Infants, and Children (WIC) <input type="checkbox"/> TANF Child Care services <input type="checkbox"/> TANF transportation services <input type="checkbox"/> Other TANF-funded services <input type="checkbox"/> Other: _____	

Client's Prior Living Situation - Prior to Project Entry				
(Select one Living Situation and answer the corresponding questions in the order in which they appear)				
Homeless Situations	Institutional Situations	Temporary Housing Situations	Permanent Housing Situation	Other
<input type="checkbox"/> Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher, Host Home shelter <input type="checkbox"/> Safe Haven	<input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail, prison or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center	<input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Staying or living in a friend's room, apartment, or house <input type="checkbox"/> Staying or living in a family member's room, apartment, or house	<input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with ongoing housing subsidy <ul style="list-style-type: none"> <input type="checkbox"/> GPD TIP housing subsidy <input type="checkbox"/> VASH housing subsidy <input type="checkbox"/> RRH or equivalent subsidy <input type="checkbox"/> HCV voucher (tenant or project based) (not dedicated) <input type="checkbox"/> Public housing unit <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Emergency Housing Voucher <input type="checkbox"/> Family Unification Program Voucher (FUP) <input type="checkbox"/> Foster Youth to Independence Initiative (FYI) <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Other permanent housing dedicated for formerly homeless persons <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy	<input type="checkbox"/> Other <input type="checkbox"/> Worker unable to determine <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
Length of Stay in Prior Living Situation (i.e. the literally homeless situation identified above)? <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more but less than one month <input type="checkbox"/> One month or more but less than 90 days <input type="checkbox"/> 90 days or more but less than one year <input type="checkbox"/> One year or longer	Length of Stay in Prior Living Situation (i.e. the institutional situation identified above)? <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more but less than one month <input type="checkbox"/> One month or more but less than 90 days <input type="checkbox"/> 90 days or more but less than one year <input type="checkbox"/> One year or longer Did you stay in the institutional situation less than 90 days?	Length of Stay in Prior Living Situation (i.e. the housing situation identified above)? <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more but less than one month <input type="checkbox"/> One month or more but less than 90 days <input type="checkbox"/> 90 days or more but less than one year <input type="checkbox"/> One year or longer Did you stay in the housing situation less than 7 nights?	Length of Stay in Prior Living Situation (i.e. the housing situation identified above)? <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more but less than one month <input type="checkbox"/> One month or more but less than 90 days <input type="checkbox"/> 90 days or more but less than one year <input type="checkbox"/> One year or longer Did you stay in the housing situation less than 7 nights?	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer

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	<input type="checkbox"/> Yes (If YES – Complete SECTION III) <input type="checkbox"/> No (If NO – End Homeless History Interview)	<input type="checkbox"/> Yes (If YES – Complete SECTION III) <input type="checkbox"/> No (If NO – End Homeless History Interview)	<input type="checkbox"/> Yes (If YES – Complete SECTION III) <input type="checkbox"/> No (If NO – End Homeless History Interview)	
<input type="checkbox"/> N/A (Complete SECTION IV Below)	On the <u>night before</u> entering the institutional situation did you stay on the streets, in emergency shelter or a safe haven? <input type="checkbox"/> Yes (If YES – Complete SECTION IV) <input type="checkbox"/> No (If NO – End Homeless History Interview)	On the <u>night before</u> entering the housing situation did you stay on the streets, in emergency shelter or a safe haven? <input type="checkbox"/> Yes (If YES – Complete SECTION IV) <input type="checkbox"/> No (If NO – End Homeless History Interview)	On the <u>night before</u> entering the housing situation did you stay on the streets, in emergency shelter or a safe haven? <input type="checkbox"/> Yes (If YES – Complete SECTION IV) <input type="checkbox"/> No (If NO – End Homeless History Interview)	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer

On the <u>night before your previous stay</u> , was that on the streets, in an Emergency Shelter, or Safe Haven? <input type="checkbox"/> No <input type="checkbox"/> Yes	Approximate date this episode of homelessness started: <input type="text"/> / <input type="text"/> / <input type="text"/>
Total <u>number of times</u> homeless on the street, in ES, or SH in the past three years <input type="checkbox"/> One time <input type="checkbox"/> Two times <input type="checkbox"/> Three times <input type="checkbox"/> Four times <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	Total <u>number of months</u> homeless on the street, in emergency shelter, or SH in the past three years _____

Domestic Violence	
Are you, or have you been a survivor of domestic or intimate partner violence?	
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	
If YES, how long ago did you have this experience?	
<input type="checkbox"/> Within the past 3 months <input type="checkbox"/> 3 to 6 months ago <input type="checkbox"/> Client doesn't know	<input type="checkbox"/> 1 year ago or more <input type="checkbox"/> 6 months to 1 year ago <input type="checkbox"/> Client prefers not to answer
If Yes, are you currently fleeing?	
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	

In the last 2 years, in what Kentucky county did you become homeless? (If Out of State please indicate):	
If you have lived in multiple Kentucky counties in the last 2 years, please specify additional county:	
If you have lived in another part of the US in the last 2 years, please specify state:	
If other location in the last 2 years, please specify:	
In what Kentucky county are you currently staying?:	
Did you have housing when you came to this county/community?:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
What is the primary reason you came to this county/community?:	<input type="checkbox"/> Access to service and resources <input type="checkbox"/> Fleeing an abusive situation

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	<input type="checkbox"/> Job Opportunities <input type="checkbox"/> Other <input type="checkbox"/> Client prefers not to answer
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HOPWA Project: Medical Assistance	
Receiving AIDS Drug Assistance Program (ADAP)?	
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	
If No, reason (for not receiving ADAP)?	
<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Client did not apply <input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Insurance type N/A for this client <input type="checkbox"/> Client prefers not to answer
Receiving Ryan White funded Medical or Dental Assistance?	
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	
If No, reason (for not receiving Ryan White)?	
<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Client did not apply <input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Insurance type N/A for this client <input type="checkbox"/> Client prefers not to answer
Has the participant been prescribed anti-retroviral drugs?	
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	

HIV/AIDS	
Start Date:	End Date:
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
If Yes for HIV/AIDS, does the client have a T-Cell (CD4) count available?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client prefers not to answer
If Yes for HIV/AIDS and a T-Cell (CD4) count is available, what is the T-Cell (CD4) count?	
If Yes for HIV/AIDS and a T-Cell (CD4) is recorded above, how was the information obtained?	<input type="checkbox"/> Medical report <input type="checkbox"/> Client report <input type="checkbox"/> Other
If Yes for HIV/AIDS, does the client have Viral Load Information available?	<input type="checkbox"/> Not Available <input type="checkbox"/> Available <input type="checkbox"/> Undetectable <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
If Yes for HIV/AIDS and Viral Load Information is available, what is the Viral Load?	
If Yes for HIV/AIDS and Viral Load is recorded above, how was the information obtained?	<input type="checkbox"/> Medical report <input type="checkbox"/> Client report <input type="checkbox"/> Other

Staff Completing (Printed Name):

Date:

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