

HMIS Standard Update Form for HOPWA – PREV & SSO projects

Effective 10/01/2025

Intake Date

 / / / / /

Entry Date

 / / / / /

ServicePoint
(HoH) ID:

 / / / / /

Project Name

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:

 / / / / / / /

Full SSN reported

Approx or Partial SSN

Client doesn't know

Client prefers not to
answer

Date of Birth:

 / / / / /

Full DOB
reported

Approx or Partial DOB

Client doesn't
know

Client prefers not to
answer

Veteran Status

Relationship to Head of Household (Must be an adult)

No

Yes

Self (Head of Household)

HoH's child

HoH's spouse or partner

HoH's other

relation member

Other: non-relation

member

Sex

Female

Client doesn't know

Male

Client prefers not to answer

Data not collected

Race and Ethnicity (Select all that apply)

- American Indian, Alaska Native, or Indigenous
- Asian or Asian American
- Black, African American, or African
- Hispanic/Latina/o
- Middle Eastern or North African
- Additional Race and Ethnicity detail: _____

- Native Hawaiian or Pacific Islander
- White
- Client doesn't know
- Client prefers not to answer

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Gender (Select all that apply)

<input type="checkbox"/> Woman (Girl, if child)	<input type="checkbox"/> Questioning
<input type="checkbox"/> Man (Boy, if child)	<input type="checkbox"/> Different Identity
<input type="checkbox"/> Culturally Specific Identity (e.g., Two-Spirit)	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Transgender	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Non-Binary	
<input type="checkbox"/> If Different Identity, Please Specify: _____	

Health Insurance

<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Yes (If yes indicate all sources that apply 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
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	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"/>			

 ****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

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<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: \$ _____	
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="radio"/> GPD TIP housing subsidy <input type="radio"/> VASH housing subsidy <input type="radio"/> RRH or equivalent subsidy <input type="radio"/> HCV voucher (tenant or project based) (not dedicated) <input type="radio"/> Public housing unit <input type="radio"/> Rental by client, with other ongoing housing subsidy <input type="radio"/> Emergency Housing Voucher <input type="radio"/> Family Unification Program Voucher (FUP) <input type="radio"/> Foster Youth to Independence Initiative (FYI) <input type="radio"/> Permanent Supportive Housing <input type="radio"/> 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)?	Length of Stay in Prior Living Situation (i.e. the institutional situation identified above)?	Length of Stay in Prior Living Situation (i.e. the housing situation identified above)?	Length of Stay in Prior Living Situation (i.e. the housing situation identified above)?	
		<input type="checkbox"/> One night or less	<input type="checkbox"/> One night or less	

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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"/> 1 year ago or more		
<input type="checkbox"/> 3 to 6 months ago	<input type="checkbox"/> 6 months to 1 year ago		
<input type="checkbox"/> Client doesn't know	<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		

<p>In the last 2 years, in what Kentucky county did you become homeless? (If Out of State please indicate)</p>	
<p>If you have lived in multiple Kentucky counties in the last 2 years, please specify additional county:</p>	

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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 <input type="checkbox"/> Job Opportunities <input type="checkbox"/> Other <input type="checkbox"/> Client prefers not to answer			

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-retrovial 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: 		
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"/> 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"/> 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?			

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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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