

HMIS Standard Update Form for PREV projects

Effective 10/1/2025

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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| | | | / | | | | / | | |
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☐ Full DOB reported

☐ Approx or Partial DOB

☐ Client doesn't know

☐ Client prefers not to answer

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

Sex

☐ Female

☐ Male

☐ Client doesn't know

☐ Client prefers not to answer

☐ Data not collected

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/o

☐ Client prefers not to answer

☐ Middle Eastern or North African

☐ Additional Race and Ethnicity detail: _____

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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?

- ☐ No
 ☐ Yes (indicate type(s) below)
 ☐ Client doesn't know
 ☐ 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 |

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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="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)? | 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)? <input type="checkbox"/> One night or less | Length of Stay in Prior Living Situation (i.e. the housing situation identified above)? <input type="checkbox"/> One night or less | |

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| <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 | <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? <input type="checkbox"/> Yes (If YES – Complete SECTION III) <input type="checkbox"/> No (If NO – End Homeless History Interview) | <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"/> Yes (If YES – Complete SECTION III) <input type="checkbox"/> No (If NO – End Homeless History Interview) | <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"/> Yes (If YES – Complete SECTION III) <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 |
| <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 |

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| On the night <u>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: <div style="border: 1px solid black; width: 100px; height: 20px; display: flex; align-items: center; justify-content: center;"> <div style="width: 25px; height: 20px; border: 1px solid black;"></div> <div style="width: 25px; height: 20px; border: 1px solid black;"></div> <div style="width: 25px; height: 20px; border: 1px solid black;"></div> <div style="width: 25px; height: 20px; border: 1px solid black;"></div> </div> |
| Total <u>number of times homeless</u> 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 answer | Total <u>number of months</u> homeless on the street, in emergency shelter, or SH in the past three years _____ |

| | |
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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? <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Within the past 3 months <input type="checkbox"/> 3 to 6 months ago <input type="checkbox"/> Client doesn't know </div> <div> <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 </div> </div> | |
| 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 | |

| | |
|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Foster Care <input type="checkbox"/> Yes <input type="checkbox"/> No | Zip Code of Last Permanent Address <div style="border: 1px solid black; width: 100px; height: 20px; display: flex; align-items: center; justify-content: center;"> <div style="width: 25px; height: 20px; border: 1px solid black;"></div> <div style="width: 25px; height: 20px; border: 1px solid black;"></div> <div style="width: 25px; height: 20px; border: 1px solid black;"></div> <div style="width: 25px; height: 20px; border: 1px solid black;"></div> </div> |
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| 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 <input type="checkbox"/> Job Opportunities <input type="checkbox"/> Other <input type="checkbox"/> Client prefers not to answer |

Staff Completing (Printed Name):

Date:

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