HMIS Standard Update Form for VA SSVF 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

☐ 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

☐ Asian or Asian American

☐ Black, African American, or African

☐ Hispanic/Latina/o

☐ Middle Eastern or North African

☐ Native Hawaiian or Pacific Islander

☐ White

☐ Client doesn't know

☐ Client prefers not to answer

☐ Additional Race and Ethnicity detail: _____

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Gender (Select all that apply)

- ☐ Woman (Girl, if child)
- ☐ Man (Boy, if child)
- ☐ Culturally Specific Identity (e.g., Two-Spirit)
- ☐ Transgender
- ☐ Non-Binary
- ☐ If Different Identity, Please Specify: _____

- ☐ Questioning
- ☐ Different Identity
- ☐ Client doesn't know
- ☐ Client prefers not to answer

Housing Move-in Date

☐☐ / ☐☐ / ☐☐

Based on the housing move-in date above, what county was the client housed in?

Unit Address

Unit City

Unit Zip

Number of bedrooms in unit

Number of people in unit

Health Insurance

- ☐ No
- ☐ Yes (identify source below)

- ☐ Client doesn't know
- ☐ Client prefers not to answer

Source

- ☐ Medicaid
- ☐ State Children's Health Insurance (KCHIP)
- ☐ Employer-Provided Health Insurance
- ☐ Private Pay Health Insurance
- ☐ Indian Health Services Program

- ☐ Medicare
- ☐ Veteran's Health Administration (VHA)
- ☐ Health Insurance obtained through COBRA
- ☐ State Health Insurance for Adults
- ☐ 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 ☐	Mental Health ☐	Chronic Health Condition ☐	☐ Alcohol ☐ Drugs ☐ Both	Developmental ☐	HIV/AIDS ☐
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

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

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

Domestic Violence

Are you, or have you been a survivor of domestic or intimate partner violence?

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

If YES, how long ago did you have this experience?

☐ Within the past 3 months ☐ 1 year ago or more
☐ 3 to 6 months ago ☐ 6 months to 1 year ago
☐ Client doesn't know ☐ Client prefers not to answer

If Yes, are you currently fleeing?

☐ No ☐ Yes
☐ Client doesn't know ☐ Client prefers not to answer

SOAR Connection

Connection with SOAR

☐ No ☐ Yes

☐ Client doesn't know ☐ Client prefers not to answer

Employed?	
☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer	
If yes,Type of Employment	
☐ Full-Time	☐ Seasonal/sporadic (including day labor)
☐ Part-Time	☐ Data not collected
In No, Why not Employed	
☐ Looking for work	☐ Not looking for work
☐ Unable to work	☐ Data not collected