

HMIS Standard Update Form for VA SSVF projects

Effective 10/01/2021

Intake Date

		/				/			
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Entry Date

		/				/			
--	--	---	--	--	--	---	--	--	--

**ServicePoint
(HoH) ID:**

--	--	--	--	--	--	--	--	--	--

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 Refused

**Social Security
Number:**

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Full SSN reported

Approx or Partial SSN

Client doesn't know

Client refused

Date of Birth:

		/				/			
--	--	---	--	--	--	---	--	--	--

Full DOB reported

Approx or Partial DOB

Client doesn't know

Client refused

Race (Select all that apply)

American Indian, Alaska Native, or Indigenous

Black, African American, or African

Native Hawaiian or Pacific Islander

Asian

White

Client doesn't know

Client refused

Gender

Female

Male

A gender other than singularly female or male (e.g., non-binary, genderfluid, agender, culturally specific gender)

Transgender

Questioning

Client doesn't know

Client refused

Ethnicity

Non-Hispanic/Non-Latin(o)(a)(x)

Hispanic/Latin(o)(a)(x)

Client doesn't know

Client refused

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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Housing Move-in Date	<input type="text"/> / <input type="text"/> / <input type="text"/>
Based on the housing move-in date above, what county was the client housed in?	
<input type="text"/>	
Unit Address	
<input type="text"/>	
Unit City	
<input type="text"/>	
Unit Zip	
<input type="text"/>	
Number of bedrooms in unit	
<input type="text"/>	
Number of people in unit	
<input type="text"/>	

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

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 refused						
	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"/>

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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 refused
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:	
\$ _____	

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 refused
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: _____	

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 refused
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 refused
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 refused

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SOAR Connection

Connection with SOAR

- No Yes
 Client doesn't know Client refused

Employed?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
If yes, Type of Employment	
<input type="checkbox"/> Full-Time	<input type="checkbox"/> Seasonal/sporadic (including day labor)
<input type="checkbox"/> Part-Time	<input type="checkbox"/> Data not collected
In No, Why not Employed	
<input type="checkbox"/> Looking for work	<input type="checkbox"/> Not looking for work
<input type="checkbox"/> Unable to work	<input type="checkbox"/> Data not collected