# STATUS UPDATE/ANNUAL ASSESSMENT

<table>
<thead>
<tr>
<th>PROJECT NAME</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CLIENT NAME</td>
<td></td>
</tr>
<tr>
<td>PROJECT STATUS DATE</td>
<td></td>
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</tbody>
</table>

## DISABLING CONDITIONS AND BARRIERS

**Do you have a physical disability?**

- [ ] No
- [ ] Yes
- [ ] Client doesn’t know
- [ ] Client refused
- [ ] Data not collected

*If yes for Physical Disability,*

**Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?**

- [ ] No
- [ ] Yes
- [ ] Client doesn’t know
- [ ] Client refused
- [ ] Data not collected

**Do you have a developmental disability?**

- [ ] No
- [ ] Yes
- [ ] Client doesn’t know
- [ ] Client refused
- [ ] Data not collected

**Do you have a chronic health condition?**

- [ ] No
- [ ] Yes
- [ ] Client doesn’t know
- [ ] Client refused
- [ ] Data not collected

*If yes for Chronic Health Condition,*

**Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?**

- [ ] No
- [ ] Yes
- [ ] Client doesn’t know
- [ ] Client refused
- [ ] Data not collected

**Have you been diagnosed with AIDS or have you tested positive for HIV?**

- [ ] No
- [ ] Yes
- [ ] Client doesn’t know
- [ ] Client refused
- [ ] Data not collected

**Do you have a mental health problem?**

- [ ] No
- [ ] Yes
- [ ] Client doesn’t know
- [ ] Client refused
- [ ] Data not collected

*If yes for Mental Health Problem,*

**Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?**

- [ ] No
- [ ] Yes
- [ ] Client doesn’t know
- [ ] Client refused
- [ ] Data not collected

**Do you have a substance abuse problem?**

- [ ] No
- [ ] Alcohol Abuse
- [ ] Drug Abuse
- [ ] Both Alcohol and Drug
- [ ] Client doesn’t know
- [ ] Client refused
- [ ] Data not collected

Revised 9/23/19
### If you have any Substance Abuse Problem, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

| No | Yes | Client doesn’t know | Client refused | Data not collected |

### Are you a survivor of domestic or intimate partner violence?

| No | Yes | Client doesn’t know | Client refused | Data not collected |

**If Yes** for survivor of domestic or intimate partner violence

**When did this experience occur?**

| Within the past three months | Three to six months ago (excluding six months exactly) | From six to twelve months ago (excluding one year exactly) | More than a year ago | Client doesn’t know | Client refused | Data not collected |

### Are you currently fleeing?

| No | Yes | Client doesn’t know | Client refused | Data not collected |

### MONTHLY INCOME AND SOURCES

**Income from Any Source**

| No | Yes | Client doesn’t know | Client refused | Data not collected |

**IF “YES” TO INCOME FROM ANY SOURCE — INDICATE ALL SOURCES THAT APPLY**

**Income Source (Check all that apply)**

- Earned Income
- Unemployment Insurance
- Worker’s Compensation
- Private Disability Insurance
- VA Service-Connected Disability Compensation
- Social Security Disability Income (SSDI)
- Supplemental Security Income (SSI)
- Retirement Income from Social Security
- VA Non-Service-Connected Disability Pension
- Pension or retirement income from a former job
- Temporary Assistance for Needy Families
- General Assistance (GA)
- Alimony or other spousal support
- Child Support
- Other Cash Income (Specify: ______________________)

**Monthly Amount**

### NON-CASH BENEFITS

**Receiving Non-Cash Benefits?**

| No | Yes | Client doesn’t know | Client refused | Data not collected |

**IF “YES” TO RECEIVING NON-CASH BENEFITS—INDICATE ALL SOURCES THAT APPLY**

- Supplemental Nutrition Assistance Program (SNAP)
- TANF Transportation Services
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Other TANF-Funded Services
- TANF Childcare Services
- Other Non-Cash Benefits (Specify Source): ______________________
HEALTH INSURANCE

<table>
<thead>
<tr>
<th>Covered by Health Insurance?</th>
<th>□ No</th>
<th>□ Client doesn't know</th>
<th>□ Yes</th>
<th>□ Client refused</th>
<th>□ Data not collected</th>
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IF “YES” TO COVERED BY HEALTH INSURANCE—INDICATE ALL SOURCES THAT APPLY

| □ MEDICAID                  | □ Insurance Obtained through COBRA |
| □ MEDICARE                 | □ Private Pay Health Insurance     |
| □ State Children’s Health Insurance Program | □ State Health Insurance for Adults |
| □ Veteran’s Administration (VA) Medical Services | □ Indian Health Services Program |
| □ Employer-provided Health Insurance | □ Other Health Insurance |
|                               | (Specify Source):_________________ |

I certify that the information above is correct to the best of my knowledge.

____________________________________________________________  __________________________
Client Signature                                              Date

____________________________________________________________  __________________________
Agency Staff Signature                                        Date

DO NOT WRITE IN BOX BELOW – DATA ENTRY PERSONNEL ONLY (Optional):

Date entered into HMIS: _____/_____/_______

<table>
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<tr>
<th>Question</th>
<th>Answer</th>
<th>Comments</th>
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<td>Was the hard copy of the Status Update/Annual Assessment form completely filled out correctly?</td>
<td>□ No</td>
<td>□ Yes</td>
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Staff Name (verifying completion of Data Entry): ____________________________________________