## 2020 OC HMIS: STATUS UPDATE/ANNUAL ASSESSMENT FORM — VASH

### 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>
</tr>
</tbody>
</table>

### DISABLING CONDITIONS AND BARRIERS

**Do you have a physical disability?**

- [ ] No
- [ ] Yes

**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

**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

**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: ______________________)

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

**Covered by Health Insurance?**
- ☐ No
- ☐ Yes
- ☐ Client doesn't know
- ☐ Client refused
- ☐ Data not collected

**IF “YES” TO COVERED BY HEALTH INSURANCE—INDICATE ALL SOURCES THAT APPLY**

<table>
<thead>
<tr>
<th>Source</th>
<th>Yes or No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ MEDICAID</td>
<td>Yes</td>
</tr>
<tr>
<td>☐ MEDICARE</td>
<td>Yes</td>
</tr>
<tr>
<td>☐ State Children’s Health Insurance Program</td>
<td>Yes</td>
</tr>
<tr>
<td>☐ Veteran’s Administration (VA) Medical Services</td>
<td>Yes</td>
</tr>
<tr>
<td>☐ Employer-provided Health Insurance</td>
<td>Yes</td>
</tr>
<tr>
<td>☐ Insurance Obtained through COBRA</td>
<td>Yes</td>
</tr>
<tr>
<td>☐ Private Pay Health Insurance</td>
<td>Yes</td>
</tr>
<tr>
<td>☐ State Health Insurance for Adults</td>
<td>Yes</td>
</tr>
<tr>
<td>☐ Indian Health Services Program</td>
<td>Yes</td>
</tr>
<tr>
<td>☐ Other Health Insurance</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Specify Source): ___________________________

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

Client Signature: ___________________________  Date: ___________________________

Agency Staff Signature: ______________________  Date: ___________________________

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

Date entered into HMIS: _____/_____/_____

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the hard copy of the Status Update/Annual Assessment form completely filled out correctly?</td>
<td>☐ No</td>
<td>☐ Yes</td>
</tr>
</tbody>
</table>

Staff Name (verifying completion of Data Entry): _________________________________