FY 2022 OC HMIS: STATUS UPDATE/ANNUAL ASSESSMENT FORM — PATH

STATUS UPDATE/ANNUAL ASSESSMENT

PROJECT NAME	
CLIENT NAME	
PROJECT STATUS DATE	☐☐—☐☐—☐☐☐☐

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

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)	**Monthly Amount**
☐ 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		
☐ 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: _____/_____/_____

Question	Answer	Comments
Was the hard copy of the Status Update/Annual Assessment form completely filled out correctly?	☐ No ☐ Yes	

Staff Name (verifying completion of Data Entry): _____