

STATUS UPDATE/ANNUAL ASSESSMENT

PROJECT NAME											
CLIENT NAME											
PROJECT STATUS DATE	<table border="1"> <tr> <td></td><td></td><td>—</td><td></td><td></td><td>—</td><td></td><td></td><td></td><td></td> </tr> </table>			—			—				
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DISABLING CONDITIONS AND BARRIERS

Do you have a physical disability?

<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<i>If yes for Physical Disability,</i> Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

Do you have a developmental disability?

<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
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Do you have a chronic health condition?

<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<i>If yes for Chronic Health Condition,</i> Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

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

<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
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Do you have a mental health problem?

<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<i>If yes for Mental Health Problem,</i> Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

Do you have a substance abuse problem?

<input type="checkbox"/> No <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol and Drug	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
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<i>If you have any Substance Abuse Problem, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
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Are you 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 <input type="checkbox"/> Data not collected	
<i>If Yes for survivor of domestic or intimate partner violence</i>		
When did this experience occur?	<input type="checkbox"/> Within the past three months <input type="checkbox"/> Three to six months ago (excluding six months exactly) <input type="checkbox"/> From six to twelve months ago (excluding one year exactly) <input type="checkbox"/> More than a year ago	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Are you currently fleeing?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

MONTHLY INCOME AND SOURCES

Income from Any Source	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY		
Income Source (Check all that apply)	Monthly Amount	
<input type="checkbox"/> Earned Income		
<input type="checkbox"/> Unemployment Insurance		
<input type="checkbox"/> Worker's Compensation		
<input type="checkbox"/> Private Disability Insurance		
<input type="checkbox"/> VA Service-Connected Disability Compensation		
<input type="checkbox"/> Social Security Disability Income (SSDI)		
<input type="checkbox"/> Supplemental Security Income (SSI)		
<input type="checkbox"/> Retirement Income from Social Security		
<input type="checkbox"/> VA Non-Service-Connected Disability Pension		
<input type="checkbox"/> Pension or retirement income from a former job		
<input type="checkbox"/> Temporary Assistance for Needy Families		
<input type="checkbox"/> General Assistance (GA)		
<input type="checkbox"/> Alimony or other spousal support		
<input type="checkbox"/> Child Support		
<input type="checkbox"/> Other Cash Income (Specify: _____)		

NON-CASH BENEFITS

Receiving Non-Cash Benefits?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
IF "YES" TO RECEIVING NON-CASH BENEFITS—INDICATE ALL SOURCES THAT APPLY		
<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP)	<input type="checkbox"/> TANF Transportation Services	
<input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	<input type="checkbox"/> Other TANF-Funded Services	
<input type="checkbox"/> TANF Childcare Services	<input type="checkbox"/> Other Non-Cash Benefits (Specify Source): _____	

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HEALTH INSURANCE

Covered by Health Insurance?	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Yes	<input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
IF "YES" TO COVERED BY HEALTH INSURANCE— INDICATE ALL SOURCES THAT APPLY		
<input type="checkbox"/> MEDICAID	<input type="checkbox"/> Insurance Obtained through COBRA	
<input type="checkbox"/> MEDICARE	<input type="checkbox"/> Private Pay Health Insurance	
<input type="checkbox"/> State Children's Health Insurance Program	<input type="checkbox"/> State Health Insurance for Adults	
<input type="checkbox"/> Veteran's Administration (VA) Medical Services	<input type="checkbox"/> Indian Health Services Program	
<input type="checkbox"/> Employer-provided Health Insurance	<input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes	

Staff Name (verifying completion of Data Entry): _____