HMIS INTERIM UPDATE FORM for PSH and RRH

Complete a new form for each update.

HEAD OF HOUSEHOLD (HoH) NAME (first, middle initial, last, suffix) HMIS CLIENT ID

|  |  |
| --- | --- |
|  |  |

INTERIM UPDATE TYPE DATE OF INTERIM UPDATE

|  Recertification / Annual Assessment |  | / / |
| --- | --- | --- |
|  Update |  |  |

MOVE-IN DATE

Complete for PSH and RRH only.

|  |
| --- |
| / / |

ADDITIONAL HOUSEHOLD MEMBERS

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name | SSN | DOB | Relationship  to HoH | Race(s)  Choose from below | Hispanic  Latino  Y/N | Gender  Choose from below | Veteran  Y/N |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

Race selections: American Indian or Alaskan Native (AI / AN), Black / African American (B), Native Hawaiian / Other Pacific Islander (NH), Asian (A), White (W)

Gender selections: Male, Female, Transgender female to male (Transgender man), Transgender male to female (Transgender woman), Gender non-conforming

CLIENT LOCATION (HoH) COUNTY WHERE SERVED

|  |  |  |
| --- | --- | --- |
|  OH-504 Mahoning County CoC |  |  |
|  OH-507 Ohio Balance of State CoC |  |  |
|  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

(See Next Page)

IF NOT VACCINATED FOR COVID-19 (Ohio Balance of State CoC Clients)

|  |  |  |
| --- | --- | --- |
| Client Name | Would the client consent to a COVID-19 vaccine at no cost? | |
|  |  Yes |  |
|  No | Concerns: |
|  |  Yes |  |
|  No | Concerns: |
|  |  Yes |  |
|  No | Concerns: |
|  |  Yes |  |
|  No | Concerns: |
|  |  Yes |  |
|  No | Concerns: |

IF CLIENT IS FULLY OR PARTIALLY VACCINATED FOR COVID-19 (Ohio Balance of State CoC Clients)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Client Name | Date Vaccine Dose Administered\* | Manufacturer\* | Contact Info  Client phone number or email address | Vaccination Documentation |
|  | / / |  Moderna  Pfizer |  |  Healthcare provider  Self-report  Vaccine card |
|  | / / |  Moderna  Pfizer |  |  Healthcare provider  Self-report  Vaccine card |
|  | / / |  Moderna  Pfizer |  |  Healthcare provider  Self-report  Vaccine card |

HAS ANYONE IN THE HOUSEHOLD EXPERIENCED CHANGES IN DISABLING CONDITIONS?

** YES** If Yes, complete table below. ** NO** If No, skip to the next table.

|  |  |
| --- | --- |
| Name | Disability of long duration that substantially limits the client's ability to live on their own |
|  |  Physical  Developmental  Chronic health condition  Mental health   HIV/AIDS  Drug abuse  Alcohol abuse  Alcohol and drug abuse |
|  |  Physical  Developmental  Chronic health condition  Mental health   HIV/AIDS  Drug abuse  Alcohol abuse  Alcohol and drug abuse |
|  |  Physical  Developmental  Chronic health condition  Mental health   HIV/AIDS  Drug abuse  Alcohol abuse  Alcohol and drug abuse |
|  |  Physical  Developmental  Chronic health condition  Mental health   HIV/AIDS  Drug abuse  Alcohol abuse  Alcohol and drug abuse |

HAS INCOME FOR ANY ADULT IN THE HOUSEHOLD CHANGED?

Income for a child is recorded as income for the adult who receives the funds.

** YES** If Yes, complete table below. ** NO** If No, skip to the next table.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Source | Amount | Recipient(s) | Source | Amount | Recipient(s) |
|  Alimony or other spousal support | $ |  |  Social Security Income (SSI) | $ |  |
|  Cash assistance / TANF | $ |  |  Social Sec Disability Income (SSDI) | $ |  |
|  Child support | $ |  |  Unemployment | $ |  |
|  Earned income | $ |  |  VA Service Connected Disability Compensation | $ |  |
|  Pension from a former job | $ |  |  VA Non-Service Connected Disability Pension | $ |  |
|  Retirement from Social Security | $ |  |  Workers’ Compensation | $ |  |
|  Private Disability Insurance | $ |  |  General Assistance | $ |  |
|  Other sources \_\_\_\_\_\_\_\_\_ | $ |  |  Other sources \_\_\_\_\_\_\_\_\_ | $ |  |
| **TOTAL MONTHLY INCOME** (Record separately for each adult.) | | | | $ |

HAVE NON-CASH BENEFITS FOR ANY ADULT IN THE HOUSEHOLD CHANGED?

Income for a child is recorded as income for the adult who receives the funds.

** YES** If Yes, complete table below. ** NO** If No, skip to the next table.

|  |  |  |  |
| --- | --- | --- | --- |
| Source | Recipient(s) | Source | Recipient(s) |
|  SNAP (Food Stamps) |  |  TANF child care services |  |
|  WIC |  |  TANF transportation services |  |
|  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  Other TANF-funded services |  |

HAS ANYONE IN THE HOUSEHOLD OBTAINED HEALTH INSURANCE?

** YES** If Yes, complete table below. ** NO** If No, skip to the next table.

|  |  |  |  |
| --- | --- | --- | --- |
| Source | Recipient(s) | Source | Recipient(s) |
|  Medicaid |  |  Employer-provided Health Insurance |  |
|  Medicare |  |  Health insurance obtained through COBRA |  |
|  State Children’s Health Insurance Program (SCHIP) |  |  Private Pay Health Insurance |  |
|  Veterans Administration (VA) Medical Services |  |  State Health Insurance for Adults |  |
|  Indian Health Services Program |  |  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

WERE ANY HOUSEHOLD MEMBERS NEWLY AFFECTED BY DOMESTIC VIOLENCE?  YES  NO

SSVF projects are not required to collect domestic violence data. You may skip this section for SSVF clients.

|  |  |
| --- | --- |
| Name | Extent of Domestic Violence |
|  |  Within the past 3 months  Within the past 6-12 months   Within the past 3-6 months  More than 1 year ago  **Currently Fleeing?  Yes  No** |
| Name | Extent of Domestic Violence |
|  |  Within the past 3 months  Within the past 6-12 months   Within the past 3-6 months  More than 1 year ago  **Currently Fleeing?  Yes  No** |