HMIS INTERIM UPDATE FORM for ODH Youth

Complete a new form for each update.

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

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

CLIENT PHONE NUMBER CLIENT EMAIL ADDRESS

Do not record in HMIS. Do not record in HMIS.

|  |  |  |
| --- | --- | --- |
| ( ) - |  |  |

INTERIM UPDATE TYPE DATE OF INTERIM UPDATE HOUSING MOVE-IN DATE

|  Recertification / Annual Assessment |  | / / |  | Complete for PSH and RRH only. |
| --- | --- | --- | --- | --- |
|  Update |  |  |  | / / |

CLIENT LOCATION

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

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 CLIENT IN THE HOUSEHOLD CHANGED?

Income for a child is recorded as income for the youth 18-24 who receives the funds.

** YES** If Yes, complete table below.

** NO**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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 HoH and each youth 18-24. | | | | $ |

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

Income for a child is recorded as income for the youth 18-24 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

IS THE CLIENT PREGNANT? (HoH)

|  |  |
| --- | --- |
|  **Yes** | Due date / / |
|  **No** |  |

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** |

CURRENT LIVING SITUATION

Complete for HoH and each youth 18-24 in the household. End Date and Information Date are the same date.

|  |  |  |  |
| --- | --- | --- | --- |
| Start Date | End Date | | Information Date / Date of Contact |
| / / | / / | | / / |
| Homeless Situations | | | |
|  Place not meant for habitation | | | |
|  Emergency shelter, including hotel or motel paid for **with** emergency shelter voucher, or RHY-funded Host Home shelter | | | |
|  Safe Haven | | | |
| Institutional Situations | | | |
|  Foster care home or foster care group home | |  Long-term care facility or nursing home | |
|  Hospital or other residential non-psychiatric medical facility | |  Psychiatric hospital or other psychiatric facility | |
|  Jail, prison, or juvenile detention facility | |  Substance abuse treatment facility or detox center | |

**(table continued on next page)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Temporary and Permanent Housing Situations | | | | |
|  Residential project or halfway house with no homeless criteria | | |  Permanent housing (other than RRH) for formerly homeless persons | |
|  Hotel or motel paid for **without** emergency shelter voucher | | |  Rental by client, with RRH or equivalent subsidy | |
|  Transitional housing for homeless persons (including homeless youth) | | |  Rental by client, with HCV voucher (tenant or project based) | |
|  Host Home (non-crisis) | | |  Rental by client in a public housing unit | |
|  Staying or living in a friend’s room, apartment or house | | |  Rental by client, no ongoing housing subsidy | |
|  Staying or living in a family member’s room, apartment or house | | |  Rental by client, with other ongoing housing subsidy | |
|  Rental by client, with GPD TIP subsidy | | |  Owned by client, with housing subsidy | |
|  Rental by client, with VASH housing subsidy | | |  Owned by client, no housing subsidy | |
| Other | | | | |
|  Other (HUD) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
|  Worker unable to determine | | | | |
|  Client doesn’t know | | | | |
|  Client refused | | | | |
|  Data not collected | | | | |
| Location Details | |  | | |
| Living Situation Verified By Agency or Organization Name | |  | | |
| Is the client going to have to leave their current living situation within 14 days? | | | | |
|  **Yes** | Has a subsequent residence been identified? | | |  Yes  No |
| Does the individual or family have resources or support networks to obtain other permanent housing? | | |  Yes  No |
| Has the client had a lease or ownership interest in a permanent housing unit the last 60 days? | | |  Yes  No |
| Has the client moved two or more times in the last 60 days? | | |  Yes  No |
|  **No** | | | | |