HMIS Project Type = HUD: Update—For Adults **HMIS ID #: _____**

Client Name: _____

Update DATE: _____/_____/_____ **Project Name: _____**

Does client have a disability of long duration (check 1 and complete following grid):

_____Yes _____No _____Client doesn't know _____Client prefers not to answer

DISABILITY DETAIL Circle for each disability type: **Y=Yes N=No DK=Doesn't Know PNA=Prefers not to answer**

Disability Type	Has disability	**IF YES:**	Expected to be of long continued and indefinite duration AND substantially impairs ability to live independently
Alcohol use disorder	Y N DK PNA		Y N DK PNA
Drug use disorder	Y N DK PNA		Y N DK PNA
Both alcohol and drug use disorders	Y N DK PNA		Y N DK PNA
Chronic health condition	Y N DK PNA		Y N DK PNA
Developmental disability	Y N DK PNA		Y N DK PNA
HIV/AIDS	Y N DK PNA		Y N DK PNA
Mental health disorder	Y N DK PNA		Y N DK PNA
Physical disability	Y N DK PNA		Y N DK PNA

Covered by health insurance (check 1 and complete grid below):

_____Yes _____No _____Client doesn't know _____Client prefers not to answer

Insurance Type	Yes	No	Insurance Type	Yes	No
MEDICAID			Employer-provided insurance		
MEDICARE			Health insurance through COBRA		
State children's health insurance			Private pay health insurance		
Veteran's Health Administration (VHA)			State health insurance for adults		
Indian Health Services Program			Other: _____		

Employed?

_____Yes _____No _____Client doesn't know _____Client prefers not to answer

Income from any source?

_____Yes _____No _____Client doesn't know _____Client prefers not to answer

Total Monthly CASH income

(write in total $ amount and complete grid below): **TOTAL $_____**

Receives Income Sources:	**Yes**	**Monthly $ Amount**	**No**	**Not Collected**
Alimony or other spousal support				
Child support				
Earned income				
General assistance				
Pension or retirement income from a job				
Private disability insurance				
Retirement income from social security				
Social Security Disability Insurance (SSDI)				
Supplemental Security Income (SSI)				
TANF				
Unemployment Insurance				

VA Non-service connected disability pension				
VA service-connected disability compensation				
Worker's Compensation				
Other (specify):				

Non-cash benefits from any source (check one and complete grid below):
_____Yes _____No _____Client doesn't know _____Client prefers not to answer

Receives the following Non-cash Benefit Types:	**Yes**	**No**	**Not Collected**
Supplemental Nutrition Assistance Program (SNAP) (food stamps)			
Special Supplemental Nutrition for Women, infants, children (WIC)			
TANF Child Care services			
TANF transportation services			
Other TANF-funded services			
Other (specify):			

PSH ONLY: Moving ON (enter under SERVICES)

Date of Moving On Assistance: _____

Moving On Assistance:

_____Subsidized housing application assistance
_____Financial assistance for Moving On (e.g., security deposit, moving expenses)
_____Non-financial assistance for Moving On (e.g., housing navigation, transition support)
_____Housing Referral/placement
_____Other (please specify): _____

PSH ONLY: General Health Status

_____Excellent _____Very good _____Good _____Fair _____Poor ____Client doesn't know _____Client prefers not to answer

ONLY FOR Street Outreach or Night by Night Emergency Shelter:

Date of Contact: _____/_____/_____

Staying on Streets, ES or SH: _____Yes _____No _____ Worker unable to determine

Date of Engagement: _____

ONLY FOR Rapid Rehousing (RRH) and Permanent Housing (PSH/OPH) Projects:

Housing Move-in Date: _____/_____/_____