HMIS #:
CM Name:
Project Entry Date:

Monterey & San Benito Counties HMIS -Standard Update

This form is designed to be completed by a service provider while interviewing a client.
A separate Standardized Update form should be completed for each member of the household.

Client Profile

First Name	**Middle**
Last Name	

Housing Move-in Date	

Monthly Income – Cash Benefits

Income from any source?	❑ Yes ❑ No ❑ Client doesn't know ❑ Client refused
Total monthly income:	$
❑ Alimony or Other Spousal Income $_____	❑ Retirement income from Social Security $_____
Date start receiving:_____	**Date start receiving:**_____
❑ Child Support $_____	❑ SSDI $_____
Date start receiving:_____	**Date start receiving:**_____
❑ Earned Income $_____	❑ SSI $_____
Date start receiving:_____	**Date start receiving:**_____
❑ General Assistance $_____	❑ TANF $_____
Date start receiving:_____	**Date start receiving:**_____
❑ Other $_____	❑ Unemployment Insurance $_____
Date start receiving:_____	**Date start receiving:**_____
If Other specify: _____	❑ VA Non-service connect disability pension $_____
❑ Pension or retirement from another job $_____	**Date start receiving:**_____
Date start receiving:_____	❑ VA Service connected disability compensation $_____
❑ Private disability insurance $_____	**Date start receiving:**_____
Date start receiving:_____	❑ Worker's compensation $_____
	Date start receiving:_____

HMIS #

Non-Cash Benefits

Income from any source?	❑ Yes ❑ No ❑ Client doesn't know ❑ Client refused
❑ Special supplement nutrition program for WIC $_____	❑ TANF Transportation services $_____
❑ Supplemental nutrition assistance program (Food Stamps) $_____	❑ Other TANF funded services $_____
❑ TANF-Child care services $_____	❑ Other Source $_____
	If Other, specify:

Health Insurance

Covered by health insurance?	❑ Yes ❑ No ❑ Client doesn't know ❑ Client refused
❑ Medicaid	❑ Private pay health plan
❑ Medicare	❑ State health insurance for adults
❑ State children's health insurance program	❑ Indian health services program
❑ VA Medical Services	❑ Other Source
❑ Employer provided	If Other, specify:

HMIS #

Disability

Does the client have a disabling condition?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused		
If Yes, please complete the following for each disability type			
Alcohol Abuse	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	Condition Long term?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Disability State Date	_____	If Yes, expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Both Alcohol & Drug Abuse	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	Condition Long term?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Disability Start Date	_____	If Yes, expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Chronic Health Condition	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	Condition Long term?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Disability Start Date	_____	If Yes, expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Developmental	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	Condition Long term?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Disability State Date	_____	If Yes, expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused

HMIS #

Disability

Drug Abuse	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	Condition Long term?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Disability State Date	_____	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
HIV/AIDS	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	Condition Long term?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Disability State Date	_____	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Mental Health Problem	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	Condition Long term?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Disability State Date	_____	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Physical	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	Condition Long term?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Disability State Date	_____	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused

Domestic Violence

Domestic Violence Victim/Survivor	❑ Yes ❑ No	❑ Client Doesn't Know ❑ Client Refused
If yes, when did experience occur	❑ Within past three months ❑ Three months to less than six months ago (excluding six months exactly) ❑ Six months to less than one year ago (excluding one year exactly) ❑ One year or more ago ❑ Client doesn't know ❑ Client refused	
If yes, are you currently fleeing?	❑ Yes ❑ No	❑ Client Doesn't Know ❑ Client Refused

HMIS #

Employment Status

Employed	❑ Yes ❑ Client Doesn't Know ❑ No ❑ Client Refused
If Yes, Type of Employment	❑ Full-time ❑ Part-time ❑ Seasonal/Sporadic (including day labor)
If No, Why Not Employed	❑ Looking for work ❑ Unable to work ❑ Not looking for work

I (Adult client or Head of Household) certify that the information I have provided here is true/correct to the best of my knowledge.

Print Name of Client	Signature of Client	Date
Print Name of Intake Worker	Signature of Intake Worker	Date