



Marin County Continuum of Care

Standard HMIS Adult Client Status Update and/or Annual Assessment

Program Name: _____ Case Worker/Intake Person: _____ Status Date: _____

CLIENT STATUS UPDATE/ANNUAL ASSESSMENT

Status Update Assessment is to be filled out every time there is a change in disabilities, income, non-cash benefits, or health insurance.

Annual Assessment is to be filled out once a year – 30 days before or after the anniversary of the program start date.

Complete this form if the client is an adult or Head of Household. A separate Standard Adult Client Status Update or Annual Assessment must be completed for each adult member of the household. A separate Status Update or Annual Assessment form must be completed for children (non-Head of Household) as well, but please be sure to use the Standard Child Status Update or Annual Assessment form.

1) Client Name	First	Last																				
2) Project Status Update or Annual Assessment 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> <tr> <td colspan="3">Month</td> <td colspan="3">Day</td> <td colspan="4">Year</td> </tr> </table>				/			/					Month			Day			Year			
		/			/																	
Month			Day			Year																
3) Housing Move-in Date [Head of Household only] <i>(Required for Permanent Housing Projects only)</i> IMPORTANT REMINDER: When a client moves into a permanent housing unit while enrolled in Rapid Rehousing, Permanent Supportive Housing or Other Permanent Housing programs, ensure the "Housing Move-In Date" on enrollment screen is completed.	<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> <tr> <td colspan="3">Month</td> <td colspan="3">Day</td> <td colspan="4">Year</td> </tr> </table>				/			/					Month			Day			Year			
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Month			Day			Year																
DISABLING CONDITIONS: A Disabling Condition is a health condition that interferes with getting and/or keeping stable housing.																						
1) Does the client have a Physical Disability? If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected																				

Client Name _____

Head of Household Name (if not Self) _____

2) Does the client have a Developmental Disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
3) Does the client have a Chronic Health Condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
4) Does the client have HIV – AIDS?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
5) Does the client have a Mental Health Disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
6) Does the client have any Substance Use Disorder?	<input type="checkbox"/> No <input type="checkbox"/> Alcohol use disorder <input type="checkbox"/> Drug use disorder <input type="checkbox"/> Both Alcohol & Drug Abuse Use Disorders	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected

DOMESTIC VIOLENCE [Head of Household and Adults only]

1) Survivor of Domestic Violence <i>Ask the client "Have you ever experienced any domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions against you or a member of your family, including a child, that has happened in the place you were living?"</i> If the answer is "no", skip to "Monthly Income – Cash Benefits" section. If the answer is "yes", COMPLETE questions 2 and 3.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
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Client Name _____

Head of Household Name (if not Self) _____

2) Most Recent Occurrence <i>Ask the client "How long ago was your most recent experience of domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions?"</i>	<input type="checkbox"/> Within the past three months <input type="checkbox"/> Three to six months ago (excluding six months exactly) <input type="checkbox"/> Six months to one year ago (excluding one year exactly) <input type="checkbox"/> One year ago or more <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
3) Current Status <i>Ask the client "Are you currently fleeing, or attempting to flee, the domestic violence situation, or are you afraid to return to the place you are living?"</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
MONTHLY INCOME – CASH BENEFITS [Head of Household and Adults only]	
Current income from any source? <i>Is the client currently receiving any income from any source?</i> Specify the type(s) and amount(s) of income the client currently receives. <i>Only regular, recurrent sources that are current today should be included. Income received for a minor (under 18 years old) member of the household (e.g., SSI) should be recorded with the HoH's information.</i> <i>DO NOT include income received by other adults (18 years and older) in the household; record their income on their Enrollment form.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected <input type="checkbox"/> Earned Income \$ _____ <input type="checkbox"/> Unemployment Insurance \$ _____ <input type="checkbox"/> Supplemental Security Income SSI \$ _____ <input type="checkbox"/> Social Security Disability Insurance SSDI \$ _____ <input type="checkbox"/> VA Service-Connected Disability Pension \$ _____ <input type="checkbox"/> VA Non-service connect disability pension \$ _____ <input type="checkbox"/> Private Disability Insurance \$ _____ <input type="checkbox"/> Worker's Compensation \$ _____ <input type="checkbox"/> Temporary Assistance for Needy Families TANF/CalWORKs \$ _____ <input type="checkbox"/> General Assistance (GA) \$ _____ <input type="checkbox"/> Retirement income from Social Security \$ _____ <input type="checkbox"/> Pension or Retirement Income from a Former Job \$ _____ <input type="checkbox"/> Child Support \$ _____ <input type="checkbox"/> Alimony and Other Spousal Support \$ _____ <input type="checkbox"/> Other Cash Income \$ _____ If Other Specify: _____ Total Monthly Cash Income for Individual TOTAL: \$ _____

Client Name _____

Head of Household Name (if not Self) _____

NON-CASH BENEFITS [Head of Household and Adults only]**Currently receiving Non-Cash Benefits?**

Is the client currently receiving one of the non-cash benefits listed below?

- ☐ Yes ☐ No ☐ Client doesn't know ☐ Client prefers not to answer
☐ Data Not Collected

If Yes, indicate all the non-cash benefits the client is receiving:

Only regular, recurrent sources that are current today should be included. Record non-cash benefits received by a minor member (under 18 years of age) of the household under the HoH's information.

DO NOT include benefits received by other adults (18 years and older) in the household; record their benefits on their Enrollment form.

- ☐ Supplemental Nutrition Assistance Program (SNAP)/Cal Fresh
☐ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
☐ TANF/CALWORKS Childcare Services
☐ TANF/CALWORKS Transportation Services
☐ Other TANF/CALWORKS-Funded Services
☐ Other Non-Cash Benefit
 If Other Specify: _____

HEALTH INSURANCE**Currently covered by health insurance?**

Is the client currently covered by health insurance?

- ☐ Yes ☐ No ☐ Client doesn't know ☐ Client prefers not to answer
☐ Data Not Collected

If Yes, type(s) of insurance(s):

If the client is currently covered by multiple health insurances please select all that apply.

- ☐ Medicaid (same as Medi-Cal)
☐ Medicare
☐ State Children's Health Insurance (CHIP) Program
☐ Veteran's Health Administration (VHA)
☐ Employer-Provided Health Insurance
☐ Health Insurance Obtained Through COBRA
☐ Private Pay Health Insurance
☐ State Health Insurance for Adults
☐ Indian Health Services Program
☐ Other Health Insurance
 If Other Specify: _____

Client Name _____

Head of Household Name (if not Self) _____