

-Continuum of Care – RHY Update  
Data Collection HMIS Form — (2021)



<b>Client ID:</b>	<b>Annual Assessment Review Date:</b>
<b>First, Mi., Last Name, Suf:</b>	
<b>Housing Move In Date:</b>	<b>Client Location: LA-503</b>

\*Note: Annual Assessment is done on clients in a program for 365 or more days. Annual Assessment Review Date should be noted in the system as one-day before 1-year anniversary date in the system.  
Example: Client Entry Date: 1/5/2018; Client Annual Assessment Review Date: 1/4/2019

**Notes:** Please make sure to end date any old monthly income, non-cash benefit, disability, health insurance, or coordinated entry event before adding new source and date (Beyond This Point). Neglecting to end date old information, will impact your data negatively.

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<b>Total Monthly Income:</b> \$ _____ (Income from any source)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected				
Source of Income	Receiving income from any source?	Amount of income	How often:	Start Date	End Date
<b>Alimony or other spousal support</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
<b>Child support</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
<b>Earned income</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
<b>Other</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
<b>Pension or retirement income from another job</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
<b>Private disability insurance</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
<b>Retirement income from social security</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
<b>SSDI</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
<b>SSI</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
<b>TANF</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
<b>Unemployment insurance</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
<b>VA Non- service connected disability pension</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
<b>Worker's compensation</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				

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<b>Non cash benefit from any source:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected
Source of non-cash benefit	Receiving income from any source?	Start Date	End Date		
Supplemental Nutritional Assistance Program (Food Stamps)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Special Supplemental Nutrition Program for WIC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
TANF Child Care Services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
TANF Transportation Services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Other TANF Funded Services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				

<b>Covered by health insurance:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected
Source of Health Insurance	Covered	Start Date	End Date		
Medicaid	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Medicare	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
State Children's Health	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Veteran's Admin Medical	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Employer Provided Health Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Health Insurance obtained through COBRA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Private pay health insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
State health insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Indian health insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				

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Disability Type	Currently Receiving Services or Treatment	Condition Long Term? (Y/N)	Start Date	Disability Determination (Y/N)	Disability Verification on File (Y/N)	End Date
Alcohol abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client don't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not completed					
Both Alcohol and Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client don't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not completed					
Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client don't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not completed					
Chronic Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client don't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not completed					
Developmental	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client don't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not completed					
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client don't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not completed					
Mental Health	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client don't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not completed					
Physical	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client don't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not completed					

**Note on Disability:**



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<b>Domestic violence victim/survivor:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected
<b>If Yes for domestic violence victim/survive; when experiences occurred:</b>	<input type="checkbox"/> Within the past 3 months	<input type="checkbox"/> 3-6 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> Data Not Collected	
	<input type="checkbox"/> More than 1 year ago	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused		
<b>If Yes for domestic violence/survivor, are you fleeing:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected
<b>Have you ever been placed in foster care:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected

**Street Outreach, Coordinated Entry and Emergency Shelter - BEYOND THIS POINT**

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## Data Collection HMIS Form — (2021)



**Date of Engagement**

\_\_\_\_/\_\_\_\_/\_\_\_\_

**Pregnant?**

- Yes    No    Client doesn't know    Client refused    Data not collected

**If Yes, Projected Birth Date**

**Notes:**