



LANE COUNTY HMIS YHDP UPDATE/INTERIM REVIEW FORM

Agency	Project Name	Client ID #	Update/Review Date
			/ /

TYPE OF ASSESSMENT

<input type="checkbox"/> 30-Day Review	<input type="checkbox"/> 90-Day Review	<input type="checkbox"/> 6-Month Review	<input type="checkbox"/> Annual Assessment
<input type="checkbox"/> 60-Day Review	<input type="checkbox"/> 120-Day Review	<input type="checkbox"/> 9-Month Review	<input type="checkbox"/> Update (used for adding HMID)

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

EXISTING HOUSEHOLD INFO

<input type="checkbox"/> full <input type="checkbox"/> partial	Is this form adding client(s) to an existing household? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, HMIS Client ID (HoH) _____
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HEAD OF HOUSEHOLD CONTACT INFO

Name	Housing status	Email	Address	Contact #
				<input type="checkbox"/> Cell Phone <input type="checkbox"/> Message Phone

Housing Status selections: Unsheltered or Emergency Shelter, Doubled up, Transitional Housing Project, Housed

HOUSEHOLD MEMBERS IN THIS UPDATE (LIST NAMES AND CLIENT IDS)

NAMES	CLIENT #

HOUSING MOVE-IN DATE (RRH and PSH Projects ONLY)

/ /

HOUSEHOLD TYPE

<input type="checkbox"/> Adult Only
<input type="checkbox"/> Adult(s) and Child(ren)
<input type="checkbox"/> Child(ren) Only

HOUSEHOLD SIZE AND INCOME same for every HH member

Household Size:	Household Income:
Level of Family Income:	Percent of Median Family Income:
<input type="checkbox"/> Up to 50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%	<input type="checkbox"/> 0-30% <input type="checkbox"/> 30-50%
<input type="checkbox"/> 101-125% <input type="checkbox"/> 126-150% <input type="checkbox"/> 151-175%	<input type="checkbox"/> 50-80% <input type="checkbox"/> Over 80%
<input type="checkbox"/> 176-200% <input type="checkbox"/> 201-250% <input type="checkbox"/> Over 250%	

ARE ANY ADULTS IN THE HOUSEHOLD CURRENTLY RECEIVING CASH INCOME?

YES NO

Income for a child is recorded as income for the adult who receives the funds.

Source	Amount	Recipient(s)	Source	Amount	Recipient(s)
<input type="checkbox"/> Alimony or other spousal support	\$		<input type="checkbox"/> Social Security Income (SSI)	\$	
<input type="checkbox"/> Cash assistance / TANF	\$		<input type="checkbox"/> Social Sec Disability Income (SSDI)	\$	
<input type="checkbox"/> Child support	\$		<input type="checkbox"/> Unemployment	\$	
<input type="checkbox"/> Earned income	\$		<input type="checkbox"/> VA Service Connected Disability Compensation	\$	
<input type="checkbox"/> Pension from a former job	\$		<input type="checkbox"/> VA Non-Service Connected Disability Pension	\$	
<input type="checkbox"/> Retirement from Social Security	\$		<input type="checkbox"/> Workers' Compensation	\$	
<input type="checkbox"/> Private Disability Insurance	\$		<input type="checkbox"/> General Assistance	\$	
<input type="checkbox"/> Other sources _____	\$		<input type="checkbox"/> Other sources _____	\$	

TOTAL MONTHLY INCOME
(Record separately for each adult.) \$

ARE ADULTS IN THE HOUSEHOLD CURRENTLY RECEIVING NON-CASH BENEFITS?

YES NO

Income for a child is recorded as income for the adult who receives the funds.

Source	Recipient(s)	Source	Recipient(s)
<input type="checkbox"/> SNAP (Food Stamps)		<input type="checkbox"/> TANF child care services	
<input type="checkbox"/> WIC		<input type="checkbox"/> TANF transportation services	
<input type="checkbox"/> Other _____		<input type="checkbox"/> Other TANF-funded services	

DOES ANYONE IN THE HOUSEHOLD HAVE HEALTH INSURANCE?

YES NO

Source	Recipient(s)	Source	Recipient(s)
<input type="checkbox"/> Medicaid		<input type="checkbox"/> Employer-provided Health Insurance	
<input type="checkbox"/> Medicare		<input type="checkbox"/> Health insurance obtained through COBRA	
<input type="checkbox"/> State Children's Health Insurance Program (SCHIP)		<input type="checkbox"/> Private Pay Health Insurance	
<input type="checkbox"/> Veterans Administration (VA) Medical Services		<input type="checkbox"/> State Health Insurance for Adults	
<input type="checkbox"/> Indian Health Services Program		<input type="checkbox"/> Other _____	

Pregnant?	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Projected Birth Date: ____/____/____
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HOUSEHOLD MEMBERS WITH DISABLING CONDITIONS

Name	Disability of long duration that substantially limits the client's ability to live on their own
	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic health condition <input type="checkbox"/> Mental health <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Drug abuse <input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Alcohol and drug abuse
	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic health condition <input type="checkbox"/> Mental health <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Drug abuse <input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Alcohol and drug abuse
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DO NOT ask any DV Questions of someone who is accompanied by another Adult

ARE ANY ADULTS AFFECTED BY DOMESTIC VIOLENCE?

YES NO

Name	Extent of Domestic Violence
	<input type="checkbox"/> Within the past 3 months <input type="checkbox"/> Within the past 6-12 months <input type="checkbox"/> Within the past 3-6 months <input type="checkbox"/> More than 1 year ago Currently Fleeing? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name	Extent of Domestic Violence
	<input type="checkbox"/> Within the past 3 months <input type="checkbox"/> Within the past 6-12 months <input type="checkbox"/> Within the past 3-6 months <input type="checkbox"/> More than 1 year ago Currently Fleeing? <input type="checkbox"/> Yes <input type="checkbox"/> No

CURRENT LIVING SITUATION (CONTACTS)

Complete separately for each adult if adults were living in different living situations.

Homeless Situations	
<input type="checkbox"/> Place not meant for habitation	
<input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter	
<input type="checkbox"/> Safe Haven	
Institutional Situations	
<input type="checkbox"/> Foster care home or foster care group home	<input type="checkbox"/> Long-term care facility or nursing home
<input type="checkbox"/> Hospital or other residential non-psychiatric medical facility	<input type="checkbox"/> Psychiatric hospital or other psychiatric facility
<input type="checkbox"/> Jail, prison, or juvenile detention facility	<input type="checkbox"/> Substance abuse treatment facility or detox center
Temporary and Permanent Housing Situations	
<input type="checkbox"/> Residential project or halfway house with no homeless criteria	<input type="checkbox"/> Staying or living in a friend's room, apartment or house
<input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher	<input type="checkbox"/> Staying or living in a family member's room, apartment or house
Is the Client going to have to leave their current living situation within 14 days: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Refused	