

Staff: _____ Project Update Date: ____/____/____ Name of Head of Household: _____

Project Name (Enter Data As): _____

Client Record

① Unless specifically required by a funder, clients may use a preferred name (rather than legal name) for HMIS purposes.

Client _____
Name _____ Client ID _____**Client location as of assessment/review date**

① Select the county in which the client is residing (or sleeping at night if unhoused). This field does not need to match the CoC Code above.

Client Location (County) _____

Housing Move-In Date

① Record the date of the first night the head of household spent living in the unit for permanent housing projects (incl. PSH, RRH, and OPH). This must be on or after the project start date. Leave blank if the client is not yet housed.

Housing Move-In Date ____/____/____

Health InsuranceCovered by Health Insurance ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answerMedicaid (MO HealthNet) ☐ No ☐ YesMedicare ☐ No ☐ YesState Children's Health Insurance Program ☐ No ☐ YesVeteran's Health Administration ☐ No ☐ YesEmployer-Provided Health Insurance ☐ No ☐ YesHealth Insurance obtained through COBRA ☐ No ☐ YesPrivate Pay Health Insurance ☐ No ☐ YesState Health Insurance for Adults ☐ No ☐ YesIndian Health Services Program ☐ No ☐ YesOther (specify): _____ ☐ No ☐ Yes

① HUD requires that the client be asked about each individual source of health insurance and requires an answer be recorded for each.

① **Data Entry Tip:**
Remember to end date old records and create new records each time a source of health insurance changes.**Monthly Income**Income from Any Source ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answerAlimony and other spousal support ☐ No ☐ Yes: \$ _____Child support ☐ No ☐ Yes: \$ _____Earned income (i.e., employment income) ☐ No ☐ Yes: \$ _____General Assistance (GA) ☐ No ☐ Yes: \$ _____Other (specify): _____ ☐ No ☐ Yes: \$ _____Pension or retirement income from a former job ☐ No ☐ Yes: \$ _____Private disability insurance ☐ No ☐ Yes: \$ _____Retirement Income from Social Security ☐ No ☐ Yes: \$ _____Social Security Disability Insurance (SSDI) ☐ No ☐ Yes: \$ _____Supplemental Security Income (SSI) ☐ No ☐ Yes: \$ _____Temporary Assistance for Needy Families (TANF) ☐ No ☐ Yes: \$ _____Unemployment Insurance ☐ No ☐ Yes: \$ _____VA Non-Service-Connected Disability Pension ☐ No ☐ Yes: \$ _____VA Service-Connected Disability Compensation ☐ No ☐ Yes: \$ _____Worker's Compensation ☐ No ☐ Yes: \$ _____

① HUD requires that the client be asked about each individual source of income and requires an answer be recorded for each. For any income sources where income is received, the monthly amount must also be recorded.

① **Data Entry Tip:**
Remember to end date old records and create new records each time a source of income changes.

Total Monthly Income \$ _____

Non-Cash Benefits

Non-Cash Benefits from Any Source ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

Supplemental Nutrition Assistance Program (SNAP)
(Previously known as Food Stamps) ☐ No ☐ Yes

Special Supplemental Nutrition Program for
Women, Infants and Children (WIC) ☐ No ☐ Yes

TANF Child Care services ☐ No ☐ Yes

TANF transportation services ☐ No ☐ Yes

Other TANF-funded services ☐ No ☐ Yes

Other (specify): _____ ☐ No ☐ Yes



HUD requires that the client be asked about each individual source of non-cash benefits and requires an answer be recorded for each.



Data Entry Tip:
Remember to end date old records and create new records each time a source of non-cash benefit changes.

Disabilities

If one or more of the options below with an asterisk(*) has been selected, the answer to “disabling condition” must be “yes.”
If none of the answers below with an asterisk(*) has been selected, the answer to “disabling condition” may be “yes” or “no.”

| Disability type | Disability determination | If yes, expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? |
|-------------------------------------|---|---|
| Alcohol Use Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA | <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA |
| Both Alcohol and Drug Use Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA | <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA |
| Chronic Health Condition | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA | <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA |
| Developmental Disability | <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA | (not applicable) |
| Drug Use Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA | <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA |
| HIV/AIDS | <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA | (not applicable) |
| Mental Health Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA | <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA |
| Physical Disability | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA | <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA |

DK = Client doesn't know; PNTA = Client prefers not to answer

Domestic Violence

“Domestic violence” is utilized here as shorthand for domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions that relate to violence against the individual or a family member.

Survivor of Domestic Violence? ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

If yes, when experience occurred

| | |
|--|---|
| <input type="checkbox"/> Within the past three months | <input type="checkbox"/> Three to six months ago |
| <input type="checkbox"/> From six to twelve months ago | <input type="checkbox"/> More than a year ago |
| <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Client prefers not to answer |

If yes, currently fleeing? ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer