

Staff: \_\_\_\_\_ Project Update Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Name of Head of Household: \_\_\_\_\_

Project Name (Enter Data As): \_\_\_\_\_

**Client Record**

**i** 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**

**i** 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**

**i** 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 Insurance**

**Covered by Health Insurance** ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

Medicaid (MO HealthNet) ☐ No ☐ Yes

Medicare ☐ No ☐ Yes

State Children's Health Insurance Program ☐ No ☐ Yes

Veteran's Health Administration ☐ No ☐ Yes

Employer-Provided Health Insurance ☐ No ☐ Yes

Health Insurance obtained through COBRA ☐ No ☐ Yes

Private Pay Health Insurance ☐ No ☐ Yes

State Health Insurance for Adults ☐ No ☐ Yes

Indian Health Services Program ☐ No ☐ Yes

Other (specify): \_\_\_\_\_ ☐ No ☐ Yes

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

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

**Disabilities**

**i** 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