ICA Missouri – HOPWA Update – TH [FY2026] Adult/HoH

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

Project Name (Enter Data As):

**Client Record**

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

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| --- | --- | --- |
| **Client** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Name | Client ID |

**Client location as of assessment/review date**

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| --- | --- |
| 🛈 | 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. |

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| **Client Location (County)** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Health Insurance**

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| --- | --- | --- | --- | --- |
| **Covered by Health Insurance** | □ No | □ Yes | □ Client doesn’t know | □ Client prefers not to answer |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Medicaid (MO HealthNet) | □ No | □ Yes |  |  |  |
| Medicare | □ No | □ Yes |  | 🛈 | HUD requires that the client be asked about  each individual source of health insurance  and requires an answer be recorded for each. |
| 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 |  | 🛈 | **Data Entry Tip:**  Remember to end date old records  and create new records each time  a source of health insurance changes. |
| Private Pay Health Insurance | □ No | □ Yes |  |
| State Health Insurance for Adults | □ No | □ Yes |  |
| Indian Health Services Program | □ No | □ Yes |  |
| Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ No | □ Yes |  |  |  |

**Monthly Income**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Income from Any Source** | □ No | □ Yes | □ Client doesn’t know | □ Client prefers not to answer |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Alimony and other spousal support | □ No | □ Yes: $\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| Child support | □ No | □ Yes: $\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | 🛈 | 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. |
| 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: $\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | 🛈 | **Data Entry Tip:**  Remember to end date old records  and create new records each time  a source of income changes. |
| 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: $\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |

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| --- | --- | --- | --- | --- |
| **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 |  | 🛈 | HUD requires that the client be  asked about each individual source  of non-cash benefits and requires  an answer be recorded for each. |
| Special Supplemental Nutrition Program for  Women, Infants and Children (WIC) | □ No | □ Yes |  |
| TANF Child Care services | □ No | □ Yes |  |  |  |
| TANF transportation services | □ No | □ Yes |  | 🛈 | **Data Entry Tip:**  Remember to end date old records  and create new records each time  a source of non-cash benefit changes. |
| Other TANF-funded services | □ No | □ Yes |  |
| Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ No | □ Yes |  |

**Disabilities**

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| --- | --- |
| 🛈 | 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 | □ Yes □ No □ DK □ PNTA | □ Yes\* □ No □ DK □ PNTA |
| Both Alcohol and Drug Use Disorders | □ Yes □ No □ DK □ PNTA | □ Yes\* □ No □ DK □ PNTA |
| Chronic Health Condition | □ Yes □ No □ DK □ PNTA | □ Yes\* □ No □ DK □ PNTA |
| Developmental Disability | □ Yes\* □ No □ DK □ PNTA | *(not applicable)* |
| Drug Use Disorder | □ Yes □ No □ DK □ PNTA | □ Yes\* □ No □ DK □ PNTA |
| HIV/AIDS | □ Yes\* □ No □ DK □ PNTA | *(not applicable)* |
| Mental Health Disorder | □ Yes □ No □ DK □ PNTA | □ Yes\* □ No □ DK □ PNTA |
| Physical Disability | □ Yes □ No □ DK □ PNTA | □ Yes\* □ No □ DK □ PNTA |

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

**Domestic Violence**

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| 🛈 | “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. |

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| **Survivor of Domestic Violence?** | □ No | □ Yes | □ Client doesn’t know | □ Client prefers not to answer |

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| --- | --- | --- | --- |
|  | **If yes, when experience occurred** | □ Within the past three months | □ Three to six months ago |
|  |  | □ From six to twelve months ago | □ More than a year ago |
|  |  | □ Client doesn’t know | □ Client prefers not to answer |

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| --- | --- | --- | --- | --- | --- |
|  | **If yes, currently fleeing?** | □ No | □ Yes | □ Client doesn’t know | □ Client prefers not to answer |

**Medical Assistance [Persons with HIV/AIDS Only]**

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| --- | --- | --- | --- | --- | --- |
| **Receiving AIDS Drug Assistance Program (ADAP)** | □ No | □ Yes | □ Client doesn’t know | | □ Client prefers not to answer |
| **If no, reason** | □ Applied; decision pending  □ Applied; client not eligible  □ Client did not apply | | | □ Insurance type N/A for this client  □ Client doesn’t know  □ Client prefers not to answer | |

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| --- | --- | --- | --- | --- | --- |
| **Receiving Ryan White-funded Medical or Dental Assistance** | □ No | □ Yes | □ Client doesn’t know | | □ Client prefers not to answer |
| **If no, reason** | □ Applied; decision pending  □ Applied; client not eligible  □ Client did not apply | | | □ Insurance type N/A for this client  □ Client doesn’t know  □ Client prefers not to answer | |

**T-Cell (CD4) and Viral Load [Persons with HIV/AIDS Only]**

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| --- | --- | --- | --- | --- | --- | --- |
| **T-Cell (CD4) Count Available** | □ No | □ Yes | | □ Client doesn’t know | | □ Client prefers not to answer |
| **If yes, T-Cell Count:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (0-1500) | | | | | |
| **If yes, how was the information obtained?** | □ Medical report | | □ Client report | | □ Other | |

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| **Viral Load Information Available** | □ No | □ Yes | | □ Client doesn’t know | | □ Client prefers not to answer |
| **If yes, count:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (0-999999) | | | | | |
| **If yes, how was the information obtained?** | □ Medical report | | □ Client report | | □ Other | |

**Prescribed Anti-Retroviral [Persons with HIV/AIDS Only]**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Has the participant been prescribed anti-retroviral drugs?** | □ No | □ Yes | □ Client doesn’t know | □ Client prefers not to answer |