

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.

Client

Name _____

Client ID _____

Client location as of assessment/review date

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) _____**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

HUD requires that the client be asked about each individual source of health insurance 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 health insurance changes.

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: \$ _____

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: \$ _____

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.

**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 ☐ 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

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

Medical Assistance [Persons with HIV/AIDS Only]

Receiving AIDS Drug Assistance Program (ADAP) ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

If no, reason
☐ Applied; decision pending ☐ Insurance type N/A for this client
☐ Applied; client not eligible ☐ Client doesn't know
☐ Client did not apply ☐ Client prefers not to answer

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 ☐ Insurance type N/A for this client
☐ Applied; client not eligible ☐ Client doesn't know
☐ Client did not apply ☐ Client prefers not to answer

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

T-Cell (CD4) Count Available	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
If yes, T-Cell Count: _____ (0-1500)				
If yes, how was the information obtained?	<input type="checkbox"/> Medical report	<input type="checkbox"/> Client report	<input type="checkbox"/> Other	
Viral Load Information Available	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
If yes, count: _____ (0-999999)				
If yes, how was the information obtained?	<input type="checkbox"/> Medical report	<input type="checkbox"/> Client report	<input type="checkbox"/> Other	

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

Has the participant been prescribed anti-retroviral drugs?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
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