

ICA Missouri – HCHV Update – ES [FY2026]

Child

Form designed for use by HCHV emergency shelters only.

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) _____

Health Insurance

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

Medicaid (MO HealthNet)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Medicare	<input type="checkbox"/> No	<input type="checkbox"/> Yes
State Children's Health Insurance Program	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Veteran's Health Administration	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Employer-Provided Health Insurance	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Health Insurance obtained through COBRA	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Private Pay Health Insurance	<input type="checkbox"/> No	<input type="checkbox"/> Yes
State Health Insurance for Adults	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Indian Health Services Program	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Other (specify): _____	<input type="checkbox"/> No	<input type="checkbox"/> 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.