



HMIS Annual Update Form

***Update Date:** ___ / ___ / ___ **Client's Name:** _____ **Primary Worker:** _____

If this is a family member, please put the Head of Household's Name here: _____

* **Income Received in Past 30 Days?** No Yes Don't Know Refused If "Yes", check off all that apply and list amounts:

<input type="checkbox"/> Earned Income: \$_____	<input type="checkbox"/> Unemployment Benefits: \$_____	<input type="checkbox"/> Veteran's Pension: \$_____
<input type="checkbox"/> SSI: \$_____	<input type="checkbox"/> SSDI: \$_____	<input type="checkbox"/> Pension from a Former Job: \$_____
<input type="checkbox"/> Veteran's Disability Payment: \$_____	<input type="checkbox"/> Private Disability Insurance: \$_____	<input type="checkbox"/> Alimony / Spousal Support: \$_____
<input type="checkbox"/> Worker's Compensation: \$_____	<input type="checkbox"/> TANF: \$_____	<input type="checkbox"/> Child Support \$_____
<input type="checkbox"/> General Public Assistance: \$_____	<input type="checkbox"/> Retirement Income from SSA: \$_____	<input type="checkbox"/> Other \$_____

* **Non-Cash Benefits Received in Past 30 Days?** No Yes Don't Know Refused If "Yes", check off all that apply:

<input type="checkbox"/> SNAP (Food Stamps)	<input type="checkbox"/> MEDICAID health insurance	<input type="checkbox"/> Temporary Rental Assistance
<input type="checkbox"/> MEDICARE health insurance	<input type="checkbox"/> State Children's Health Insurance Program	<input type="checkbox"/> Other Source
<input type="checkbox"/> Supplemental Nutrition Program (WIC)	<input type="checkbox"/> Veteran's Administration Medial Services	
<input type="checkbox"/> TANF Child-Care Services	<input type="checkbox"/> TANF Transportation Service	
<input type="checkbox"/> Other TANF-Funded Services	<input type="checkbox"/> Section 8, Public Housing, or other ongoing rental assistance	

* Employment Status:	Number of Hours Worked	Employment Tenure:	Looking For Work:
<input type="radio"/> Yes		<input type="radio"/> Permanent	<input type="radio"/> Yes
<input type="radio"/> No	in the Past Week: _____	<input type="radio"/> Temporary	<input type="radio"/> No
<input type="radio"/> Don't Know		<input type="radio"/> Seasonal	<input type="radio"/> Don't Know
<input type="radio"/> Refused		<input type="radio"/> Don't Know	<input type="radio"/> Refused
		<input type="radio"/> Refused	

* **Highest Level of School Completed:**

- No schooling completed
- Nursery School to 4th Grade
- 5th or 6th Grade
- 7th or 8th Grade
- 9th Grade
- 10th Grade
- 11th Grade
- 12th Grade but No Diploma
- High School Diploma
- GED
- Post-Secondary School
- Don't Know
- Refused

* Post-Secondary Degree:	Received Vocational	Current Student:
<input type="checkbox"/> None <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	Training or	<input type="radio"/> Yes
<input type="checkbox"/> Associates Degree	Apprenticeship Certificate:	<input type="radio"/> No
<input type="checkbox"/> Bachelors	<input type="radio"/> Yes <input type="radio"/> Don't Know	<input type="radio"/> Don't Know
<input type="checkbox"/> Masters	<input type="radio"/> No <input type="radio"/> Refused	<input type="radio"/> Refused
<input type="checkbox"/> Doctorate		
<input type="checkbox"/> Other Graduate/Professional Degree		
<input type="checkbox"/> Certificate of Advanced Training or skilled artisan		

Special Needs	Does the client have this condition:	If Yes, is the Client receiving services or treatment for this condition:
* <u>Physical Disability:</u>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused	> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused
* <u>Developmental Disability:</u>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused	> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused
* <u>Chronic Health Condition:</u>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused	> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused
* <u>HIV / AIDS:</u>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused	> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused
* <u>Mental Health:</u>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused	> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused
* <u>Substance Abuse Problem:</u>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused	> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused
	If "Yes" select type: <input type="radio"/> Alcohol Abuse <input type="radio"/> Drug Abuse <input type="radio"/> Both Drug & Alcohol Abuse	
* <u>Domestic Violence Victim:</u>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/> Refused	If Yes, how long ago did the experience occur: <input type="radio"/> Within the past 3 months <input type="radio"/> 3 to 6 months ago <input type="radio"/> 6 to 12 months ago <input type="radio"/> More than 12 months <input type="radio"/> Don't Know <input type="radio"/> Refused
* Note: A serious disability is expected to be of a long-continued and indefinite duration and substantially impair the client's ability to live independently. The client may have special needs that do not qualify as disabling conditions.		

Staff / Volunteer that collected this information: _____

This form may be modified to add additional questions, however the content of the existing questions should not be changed.

Instructional material and definitions for all questions can be found on our website: <http://www.in.gov/ihcda/3120.htm>