

HMIS # _____

Client Name _____

Staff Name _____

Date _____

Santa Cruz County HMIS – HOPWA Adult Status Update and/or Annual Assessment

As of February 1st, 2025 a service provider must complete a HOPWA Adult Status Update Assessment during the months of - February, May, August, **and** November when an adult client or the Head of Household has been enrolled in a HOPWA-funded program, regardless of whether their information has changed. ***After the client has been enrolled in the program for 1 year, the service provider must complete a HOPWA Adult Annual Assessment in lieu of a Status Assessment.*** This form can be used for either the Status Assessment or Annual Assessment because the same information is collected, however, please be sure to select the appropriate Assessment type when entering this data into the HMIS. Separate HOPWA Status Update and/or Annual Assessments should be completed for each client who is **over** the age of 17 or the Head of Household. **Status Update and/or Annual Assessments must be completed for children as well, but please be sure to use the HOPWA Child Status Update and/or Annual Assessment Form.**

Project Status Update Date

		/			/				
Month			Day			Year			

Disabling Conditions (All Responses required)

A Disabling Condition is a health condition that interferes with getting and/or keeping stable housing. This question is used with other information to determine if the client meets the criteria for chronic homelessness.

1) Does the client have a Physical Disability? <i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
2) Does the client have a Developmental Disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
3) Does the client have a Chronic Health Condition? <i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer

Client Name _____

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4) Does the client have HIV – AIDS? <i>If Yes, please be sure to answer the required HIV/AIDS questions below.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
5) Does the client have a Mental Health Disorder? <i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
6) Does the client have any Substance Use Disorder? <i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Alcohol use disorder <input type="checkbox"/> Drug use disorder <input type="checkbox"/> Both Alcohol & Drug Abuse Use Disorders	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer

Domestic Violence [Head of Household and Adults]

1) Survivor of Domestic Violence <i>Ask the client "Have you ever experienced any domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions against you or a member of your family, including a child, that has happened in the place you were living?"</i> <i>If the answer is "no", skip to "Monthly Income – Cash Benefits" section.</i> <i>If the answer is "yes", COMPLETE questions 2 and 3.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
2) When experienced <i>Ask the client "How long ago was your most recent experience of domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions against you or a member of your family?"</i>	<input type="checkbox"/> Within the past three months <input type="checkbox"/> Three to six months ago (excluding six months exactly) <input type="checkbox"/> Six months to one year ago (excluding one year exactly) <input type="checkbox"/> One year ago or more <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer

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<p>3) Are you currently fleeing?</p> <p><i>Ask the client "Are you currently fleeing, or attempting to flee, the domestic violence situation, or are you afraid to return to the place you are living against you or a member of your family?"</i></p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p><input type="checkbox"/> Client doesn't know</p> <p><input type="checkbox"/> Client prefers not to answer</p>
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Monthly Income – Cash Benefits [Head of Household and Adults]

<p>Income from Any Source? <i>Is the client currently receiving any income from any source?</i></p> <p>If yes, specify the type(s) and amount(s) of income the client currently receives.</p> <p><i>Only regular, recurrent sources that are current today should be included. Income received for a minor (under 18 years old) member of the household (e.g., SSI) should be recorded with the HoH's information.</i></p> <p><i>DO NOT include income received by other adults (18 years and older) in the household; record their income in their Program Enrollment</i></p> <p>Total Cash Income for Individual</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer</p>
	<p><input type="checkbox"/> Earned Income \$ _____</p> <p><input type="checkbox"/> Unemployment Insurance \$ _____</p> <p><input type="checkbox"/> Supplemental Security Income SSI (<i>SSI - received by persons who are disabled and do not have a significant work history</i>) \$ _____</p> <p><input type="checkbox"/> Social Security Disability Insurance SSDI (<i>SSDI - received by persons who are disabled and have a significant work history</i>) \$ _____</p> <p><input type="checkbox"/> VA Service-Connected Disability Pension\$ _____</p> <p><input type="checkbox"/> VA Non-service connect disability pension \$ _____</p> <p><input type="checkbox"/> Private Disability Insurance \$ _____</p> <p><input type="checkbox"/> Worker's Compensation \$ _____</p> <p><input type="checkbox"/> Temporary Assistance for Needy Families TANF/CalWORKs \$ _____</p> <p><input type="checkbox"/> General Assistance (GA) \$ _____</p> <p><input type="checkbox"/> Retirement income from Social Security \$ _____</p> <p><input type="checkbox"/> Pension or Retirement Income from a Former Job \$ _____</p> <p><input type="checkbox"/> Child Support \$ _____</p> <p><input type="checkbox"/> Alimony and Other Spousal Support \$ _____</p> <p><input type="checkbox"/> Other Cash Income \$ _____</p> <p>If Other Specify: _____</p> <p>TOTAL: \$ _____</p>

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Non-Cash Benefits [Head of Household and Adults]

Receiving Non-Cash Benefits? <i>Is the client currently receiving one of the non-cash benefits listed below?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
If Yes, indicate all the non-cash benefits the client is receiving: <i>Only regular, recurrent sources that are current today should be included. Record non-cash benefits received by a minor member (under 18 years of age) of the household under the HoH's information.</i> <i>DO NOT include benefits received by other adults (18 years and older) in the household; record their benefits in their Program Enrollment</i>	<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP/CalFresh) <input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) <input type="checkbox"/> TANF/CALWORKS Childcare Services <input type="checkbox"/> TANF/CALWORKS Transportation Services <input type="checkbox"/> Other TANF/CALWORKS-Funded Services <input type="checkbox"/> Other Non-Cash Benefit If Other Specify: _____

Health Insurance

Covered by health insurance? <i>Is the client currently covered by health insurance?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
If Yes, select the client's type(s) of health insurance(s) coverage: <i>If the client is currently covered by multiple health insurances, select all that apply.</i>	<div data-bbox="597 1087 1039 1396"> <input type="checkbox"/> Medicaid (Medi-Cal) <input type="checkbox"/> Applied; Decision Pending <input type="checkbox"/> Applied; Client Not Eligible <input type="checkbox"/> Client Did Not Apply <input type="checkbox"/> Insurance Type N/A for this Client <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer </div> <div data-bbox="597 1423 1039 1732"> <input type="checkbox"/> Medicare <input type="checkbox"/> Applied; Decision Pending <input type="checkbox"/> Applied; Client Not Eligible <input type="checkbox"/> Client Did Not Apply <input type="checkbox"/> Insurance Type N/A for this Client <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer </div>

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	<input type="checkbox"/> State Children's Health Insurance (CHIP) Program <input type="checkbox"/> Applied; Decision Pending <input type="checkbox"/> Applied; Client Not Eligible <input type="checkbox"/> Client Did Not Apply <input type="checkbox"/> Insurance Type N/A for this Client <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
	<input type="checkbox"/> Veteran's Health Administration (VHA) <input type="checkbox"/> Applied; Decision Pending <input type="checkbox"/> Applied; Client Not Eligible <input type="checkbox"/> Client Did Not Apply <input type="checkbox"/> Insurance Type N/A for this Client <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
	<input type="checkbox"/> Employer-Provided Health Insurance <input type="checkbox"/> Applied; Decision Pending <input type="checkbox"/> Applied; Client Not Eligible <input type="checkbox"/> Client Did Not Apply <input type="checkbox"/> Insurance Type N/A for this Client <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
	<input type="checkbox"/> Health Insurance Obtained Through COBRA <input type="checkbox"/> Applied; Decision Pending <input type="checkbox"/> Applied; Client Not Eligible <input type="checkbox"/> Client Did Not Apply <input type="checkbox"/> Insurance Type N/A for this Client <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
	<input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> Applied; Decision Pending <input type="checkbox"/> Applied; Client Not Eligible <input type="checkbox"/> Client Did Not Apply <input type="checkbox"/> Insurance Type N/A for this Client <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer

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	<input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Applied; Decision Pending <input type="checkbox"/> Applied; Client Not Eligible <input type="checkbox"/> Client Did Not Apply <input type="checkbox"/> Insurance Type N/A for this Client <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	
	<input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Applied; Decision Pending <input type="checkbox"/> Applied; Client Not Eligible <input type="checkbox"/> Client Did Not Apply <input type="checkbox"/> Insurance Type N/A for this Client <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	
	<input type="checkbox"/> Other Health Insurance If Other Specify: _____	

Medical Assistance [All Household Members with HIV/AIDS]

Is the client receiving AIDS Drug Assistance Program (ADAP)?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	
If No for "Receiving AIDS Drug Assistance Program (ADAP)," please select the appropriate reason:	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	
Is the client receiving AIDS Drug Assistance Program (ADAP)?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	
If No for "Receiving AIDS Drug Assistance Program (ADAP)," please select the appropriate reason:	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer

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T-cell (CD4) and Viral Load [All Household Members with HIV/AIDS]

<p>T-Cell (CD4) Count Available?</p> <p>If Yes to “T-Cell (CD4) Count Available,” then please collect the T-cell Count number: <i>Integer between 0-1500</i></p> <p>If a number is entered in the T-Cell (CD4) count, then how was the information obtained?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer</p> <p><input type="checkbox"/> Medical Report <input type="checkbox"/> Client Report <input type="checkbox"/> Other</p>
<p>Viral Load Information Available?</p> <p>If “Viral Load Information Available,” then please collect the Viral Load Count: <i>Integer between 0-999999</i></p> <p>If a number is entered in the Viral Load count, then how was the information obtained?</p>	<p><input type="checkbox"/> Not Available <input type="checkbox"/> Available <input type="checkbox"/> Undetectable <input type="checkbox"/> Client doesn't know</p> <p><input type="checkbox"/> Client prefers not to answer</p> <p><input type="checkbox"/> Medical Report <input type="checkbox"/> Client Report <input type="checkbox"/> Other</p>

Prescribed Anti-Retroviral [All Household Members with HIV/AIDS]

<p>Has the participant been prescribed anti-retroviral drugs?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer</p>
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Reminder: Housing Move-in Date [Head of Household]

(Required for Permanent Housing Projects)

IMPORTANT REMINDER: If the client moved into a permanent housing unit while enrolled in Rapid Rehousing, Permanent Supportive Housing, or Other Permanent Housing programs, **ensure the “Housing Move-In Date” on enrollment screen is completed with the date the client/household moved into the permanent unit.**

Client Name _____

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