HMIS # _____

Client Name _____

Staff Name _____

Date _____

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

As of February 1st, 2025 a service provider must complete a HOPWA Child Status Update Assessment during the months of - February, May, August, **and** November when a child client 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 Child 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. ***A separate HOPWA Status and/or Annual Assessment Form must be completed for each child member of the household (non-Head of Household). A separate HOPWA Status and/or Annual Assessment Form must be completed for adult clients and the Head of Household as well, but please be sure to use the HOPWA Adult Status 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?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer
If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer
2) Does the client have a Developmental Disability?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer
3) Does the client have a Chronic Health Condition?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer

Client Name _____

Head of Household Name (if not Self) _____

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

Health Insurance

Covered by health insurance? *Is the client currently covered by health insurance?*	❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer

Client Name _____

Head of Household Name (if not Self) _____

If Yes, select they client's type(s) of health insurance(s) coverage: *If the client is currently covered by multiple health insurances please select all that apply.*	❑ Medicaid (Medi-Cal) ❑ 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
	❑ Medicare ❑ 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
	❑ State Children's Health Insurance (CHIP) Program ❑ 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
	❑ Veteran's Health Administration (VHA) ❑ 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

Client Name _____

Head of Household Name (if not Self) _____

	❑ Employer-Provided Health Insurance ❑ 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
	❑ Health Insurance Obtained Through COBRA ❑ 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
	❑ Private Pay Health Insurance ❑ 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
	❑ State Health Insurance for Adults ❑ 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

Client Name _____

Head of Household Name (if not Self) _____

	❑ Indian Health Services Program ❑ 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
	❑ Other Health Insurance If Other Specify: _____

Medical Assistance [All Household Members with HIV/AIDS]

Is the client receiving AIDS Drug Assistance Program (ADAP)?	❑ No ❑ Yes ❑ Client doesn't know ❑ Client prefers not to answer
If No for "Receiving AIDS Drug Assistance Program (ADAP)," please select the appropriate 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
Is the client receiving AIDS Drug Assistance Program (ADAP)?	❑ No ❑ Yes ❑ Client doesn't know ❑ Client prefers not to answer
If No for "Receiving AIDS Drug Assistance Program (ADAP)," please select the appropriate 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

Client Name _____

Head of Household Name (if not Self) _____

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

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

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

Has the participant been prescribed anti-retroviral drugs?	❑ No ❑ Yes ❑ Client doesn't know ❑ Client prefers not to answer

Client Name _____

Head of Household Name (if not Self) _____