MSHMIS Update

Review Date: _______________ **Review Type: (30 day, 60 day, annual, etc.)** _________________

*** ***

Please Update Any Responses that Have Changed Since Entry / Last Review

*** ***

Answer this section for all persons in household (use additional sheets for larger families)

Name & Client ID *(Please Answer for All Persons in HH)*	**Active Duty US Military Veteran**	**Currently Covered by Health Insurance?**	***(If Client has Health Insurance)*** **Select All Type(s) That Apply**	**Housing Move In Date**	**Pregnant?**
	(Answer for adults 18+ only) ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ MEDICAID ☐ MEDICARE ☐ State Children's Health Insurance Program ☐ Veteran Administration (VA) Medical Services ☐ Employer Provided Health Insurance ☐ Health Insurance Obtained through COBRA ☐ Private Pay Health Insurance ☐ State Health Insurance for Adults ☐ Indian Health Services Program ☐ Other (If Other Specify)_________________	Housing Move-In Date: ____/_____/____ *For clients who have moved into permanent housing via the Rapid-Rehousing project and Permanent Housing projects*	☐ Yes ☐ No *(If Yes)* Projected Date of Birth ________
	(Answer for adults 18+ only) ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ MEDICAID ☐ MEDICARE ☐ State Children's Health Insurance Program ☐ Veteran Administration (VA) Medical Services ☐ Employer Provided Health Insurance ☐ Health Insurance Obtained through COBRA ☐ Private Pay Health Insurance ☐ State Health Insurance for Adults ☐ Indian Health Services Program ☐ Other (If Other Specify)_________________	Housing Move-In Date: ____/_____/____ *For clients who have moved into permanent housing via the Rapid-Rehousing project and Permanent Housing projects*	☐ Yes ☐ No *(If Yes)* Projected Date of Birth ________
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Answer this section for all persons in household (use additional sheets for larger families)

Name *(Please Answer for All Persons in HH)*	**Does the client have a disabling condition?**	**If client has a disabling condition, please answer the following sub-assessment questions:** *Disability Type (Select all that apply)*	*Disability Determination*	*If Yes, to be long-continued and indefinite duration and substantially impairs ability to live independently?*	*Long Term (Yes/No)*
	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Physical ☐ Developmental ☐ Chronic Health Condition ☐ HIV/AIDS ☐ Mental Health Problems ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol & Drug Abuse	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	
	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Physical ☐ Developmental ☐ Chronic Health Condition ☐ HIV/AIDS ☐ Mental Health Problems ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol & Drug Abuse	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	
	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Physical ☐ Developmental ☐ Chronic Health Condition ☐ HIV/AIDS ☐ Mental Health Problems ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol & Drug Abuse	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	

****Answer the following questions for HEAD OF HOUSEHOLD and ADULTS only! (Print additional pages where needed) ****

Income and Non-Cash Benefit Information

Total Monthly Income (per household member) $_____

Currently receiving income from any source? □ Yes □ No □ Client doesn't know □ Client refused
(If Yes, complete sub-assessment)

MONTHLY INCOME sub-assessment

X	Source of Income (Monthly)	Family Member	Amount from Source
	Alimony or Other Spousal Support		$ .00
	Child Support		$ .00
	Earned Income *(Employment)*		$ .00
	General Assistance		$ .00
	Pension or Retirement Income from a Former Job		$ .00
	Private Disability Insurance		$ .00
	Retirement Income from Social Security		$ .00
	SSDI *(Social Security Disability Insurance)*		$ .00
	SSI *(Supplemental Security Income)*		$ .00
	TANF *(Temporary Assistance for Needy Families or FIP grant)*		$ .00
	Unemployment Insurance		$ .00
	VA Service-Connected Disability Compensation		$ .00
	VA Non-Service-Connected Disability Pension		$ .00
	Workers Compensation		$ .00
	Other *(Including Gifts from Friends and Family)*		$ .00
	No Financial Resources		$ .00
	Total Monthly Income Reported		$ .00

(If Other Source), **Specify** _____

Currently receiving any non-cash benefits? □ Yes □ No □ Client doesn't know □ Client refused
(If Yes, complete sub-assessment)

NON-CASH BENEFIT sub-assessment

X	Source of Non-Cash Benefit (Monthly)	Family Member	Amount (if applicable)
	Supplemental Nutrition Assistance Program *(Food Stamps)*		$ .00
	Special Supplemental Nutrition Program for WIC		$ .00
	TANF Child Care Services		$ .00
	TANF Transportation Services		$ .00
	Other TANF Funded-Services		$ .00
	Other Source		$ .00

(If Other Source), **Specify**_____

Domestic Violence

*Domestic Violence Victim/Survivor should be indicated as **"Yes"** if the person has experienced any 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, including a child, that has taken place **within the individual's or family's primary nighttime residence.***

Domestic Violence Victim/Survivor?

- ☐ Yes
- ☐ No
- ☐ Client doesn't know
- ☐ Client refused

***(If yes)* When Experience Occurred**

- ☐ Within the past three months
- ☐ Three to six months ago (excluding six months exactly)
- ☐ Six months to one year ago (excluding one year exactly)
- ☐ One year ago or more
- ☐ Client doesn't know
- ☐ Client refused

*Currently fleeing should be indicated as **"Yes"** if the Person is fleeing, or is attempting to flee, the domestic violence situation **or** is afraid to return to their primary nighttime residence.*

***(If yes)* Are you currently fleeing?**

- ☐ Yes
- ☐ No
- ☐ Client doesn't know
- ☐ Client refused

Overview of domestic violence

_____

Additional Updates

Connection With SOAR?

- ☐ Yes
- ☐ No
- ☐ Client doesn't know
- ☐ Client refused

Client Location *(CoC Code):* _____ **(Answer for Head of Household Only)**

Contact Information

Client's Cell Phone Number _____

Emergency Contact's Name _____

Contact Type (Relationship to Client) _____

Phone Number _____

Second Phone Number _____

Email Address _____

Contact's Address: Street _____ **City** _____ **State** _____

Contact's Zip Code _____

CONTACTS & ENGAGEMENT
(REQUIRED FOR ALL STREET OUTREACH AND NBN SHELTERS)

Street Outreach Projects and **Emergency Shelters using the Night-by-Night Method of Tracking** MUST record the date and if the client is staying on the streets, ES or SH of **EACH CONTACT** made with clients including the **'Date of Engagement**'.
Please see the *HMIS Data Collection – Street Outreach Supplemental Form* and
2017 HUD Data Standards for more information