



Napa County Continuum of Care

Standard HMIS Child Client Status Update and/or Annual Assessment

Program Name: _____ Case Worker/Intake Person: _____ Date: _____

CLIENT STATUS UPDATE/ANNUAL ASSESSMENT

Status Update Assessment is to be filled out every time there is a change in disabilities, income, non-cash benefits, or health insurance.

Annual Assessment is to be filled out once a year – 30 days before or after the anniversary of the program start date.

Separate Status Update and/or Annual Assessments should be completed for each client who is **under** the age of 18 unless they are the Head of Household. **Status Update and/or Annual Assessments must be completed for adults as well, but please be sure to use the Standard HMIS Adult Status Update and/or Annual Assessment Form.**

1) Client Name	First	Last																				
2) Project Status Update or Annual Assessment Date	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25%;"> </td> <td style="width: 25%;"> </td> <td style="width: 25%;"> </td> <td style="width: 25%;"> </td> </tr> <tr> <td> </td> <td>/</td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td>/</td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td>Month</td> <td>Day</td> <td>Year</td> <td> </td> </tr> </table>						/					/						Month	Day	Year		
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Month	Day	Year																				

DISABLING CONDITIONS: A Disabling Condition is a health condition that interferes with getting and/or keeping stable housing.

1) Does the client have a Physical Disability?	<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"/> Data Not Collected
If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?	<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"/> Data Not Collected
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 <input type="checkbox"/> Data Not Collected
3) Does the client have a Chronic Health Condition?	<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"/> Data Not Collected
If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?	<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"/> Data Not Collected

Client Name _____

Head of Household Name (if not Self) _____

<p>4) Does the client have HIV – AIDS?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected</p>
<p>5) Does the client have a Mental Health Disorder?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected</p>
<p>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected</p>
<p>6) Does the client have any Substance Use Disorder?</p>	<p><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</p>	<p><input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected</p>
<p>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected</p>

HEALTH INSURANCE

<p>Currently covered by health insurance? <i>Is the client currently covered by health insurance?</i></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 <input type="checkbox"/> Data Not Collected</p>
<p>If Yes, type(s) of insurance(s): <i>If the client is currently covered by multiple health insurances please select all that apply.</i></p>	<p><input type="checkbox"/> Medicaid (same as Medi-Cal) <input type="checkbox"/> Medicare <input type="checkbox"/> State Children's Health Insurance (CHIP) Program <input type="checkbox"/> Veteran's Health Administration (VHA) <input type="checkbox"/> Employer-Provided Health Insurance <input type="checkbox"/> Health Insurance Obtained Through COBRA <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Other Health Insurance If Other Specify: _____</p>

Client Name _____

Head of Household Name (if not Self) _____