THE COALITION
OF HOMELESS SERVICES PROVIDERS

HMIS # _____
CM Name _____
Project Entry Date ____/____/____

Monterey/San Benito County HMIS - Standard Update/Annual Update

This form is designed to be completed by a service provider while interviewing a client.
A separate Standard Update form should be completed for each member of the household.

Client Profile

First Name	**Middle**
Last Name	
Alias (If multiple aliases, separate by commas)	

Domestic Violence Victim/Survivor

Domestic Violence Victim/Survivor ❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	Last Occurrence? How long ago did the person have the most recent experience?	❑ 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
Are You Currently Fleeing?	Are you currently fleeing domestic violence?	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused

Monthly Income – Cash Benefits

Income from any source?	❑ Yes ❑ No ❑ Client doesn't know ❑ Client refused
❑ Earned Income $_____	❑ Supplemental Security Income SSI $_____
❑ Unemployment Insurance $_____	❑ Retirement income from Social Security $_____
❑ Worker's Compensation $_____	❑ VA Non-service connect disability pension $_____
❑ Private Disability Insurance $_____	❑ Pension or Retirement Income from a Former Job $_____
❑ VA Service-Connected Disability Pension $_____	❑ Temporary Assistance for Needy Families TANF $_____
❑ Social Security Disability Insurance SSDI $_____	❑ General Assistance (GA) $_____ ❑ Alimony and Other Spousal Support $_____ ❑ Child Support $_____ ❑ Other Cash Income $_____ If Other Specify: _____
Total Cash Income for Individual	**TOTAL**: $_____

Non-Cash Benefits

Receiving Non-Cash Benefits?	❑ Yes ❑ No ❑ Client doesn't know ❑ Client refused
❑ Supplemental Nutrition Assistance Program (SNAP) ❑ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) ❑ TANF Childcare Services	❑ TANF Transportation Services ❑ Other TANF-Funded Services ❑ Other Non-Cash Benefit If Other Specify: _____

Health Insurance

Covered by health insurance?	❑ Yes ❑ No ❑ Client doesn't know ❑ Client refused
❑ Medicaid ❑ Medicare ❑ State Children's Health Insurance Program ❑ Veteran's 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 Health Insurance If Other Specify: _____

I, (Adult client or Head of Household) certify that the information I have provided here is true/correct to the best of my knowledge.

Print Name of Client	Signature of Client	Date
Print Name of Intake Worker	Signature of Intake Worker	Date