ICA Missouri – YHDP Update – SSO Practice Case Part 2 [FY2024] Adult/HoH

Your client stopped by to give you updates about their household. **BE SURE TO SET YOUR ENTER DATA AS (EDA) MODE AND BACK DATE BEFORE ENTERING THE INFORMATION BELOW!!!!**

Staff: _____ Project Update Date: **[The 15th of last month]** _ Name of Head of Household: **Jordan [use your last name]**

Project Name (Enter Data As): **[Use SSO project name provided in email as EDA]** _____

Client Record

ⓘ	Unless specifically required by a funder, clients may use a preferred name (rather than legal name) for HMIS purposes.

Client **Jordan [use your last name]** **[HMIS created and is same as at entry]**

Name Client ID

Client location as of assessment/review date

ⓘ	Select the county in which the client is residing (or sleeping at night if unhoused). This field does not need to match the CoC Code above.

Client Location (County) **[no change]**

Housing Move-In Date [Rapid ReHousing projects only]

ⓘ	Record the date of the first night the head of household spent living in the unit for permanent housing projects (incl. PSH, RRH, and OPH). This must be on or after the project start date. Leave blank if the client is not yet housed.

Housing Move-In Date **[leave blank for this type of project]**

Health Insurance

Covered by Health Insurance ☐ No **X Yes** ☐ Client doesn't know ☐ Client prefers not to answer

Medicaid (MO HealthNet)	☐ No	**X** Yes
Medicare	**X** No	☐ Yes
State Children's Health Insurance Program	**X** No	☐ Yes
Veteran's Health Administration	**X** No	☐ Yes
Employer-Provided Health Insurance	**X** No	☐ Yes
Health Insurance obtained through COBRA	**X** No	☐ Yes
Private Pay Health Insurance	**X** No	☐ Yes
State Health Insurance for Adults	**X** No	☐ Yes
Indian Health Services Program	**X** No	☐ Yes
Other (specify): _____	**X** No	☐ Yes

ⓘ	HUD requires that the client be asked about each individual source of health insurance and requires an answer be recorded for each.

ⓘ	**Data Entry Tip:** Remember to end date old records and create new records each time a source of health insurance changes.

Monthly Income

Income from Any Source ☐ No **X Yes** ☐ Client doesn't know ☐ Client prefers not to answer

Alimony and other spousal support	**X** No	☐ Yes: $_____
Child support	**X** No	☐ Yes: $_____
Earned income (i.e., employment income)	☐ No	**X Yes: $ 350**
General Assistance (GA)	**X** No	☐ Yes: $_____
Other (specify): _____	**X** No	☐ Yes: $_____
Pension or retirement income from a former job	**X** No	☐ Yes: $_____
Private disability insurance	**X** No	☐ Yes: $_____

ⓘ	HUD requires that the client be asked about each individual source of income and requires an answer be recorded for each. For any income sources where income is received, the monthly amount must also be recorded.

Retirement Income from Social Security	**X** No	☐ Yes: $_____
Social Security Disability Insurance (SSDI)	**X** No	☐ Yes: $_____
Supplemental Security Income (SSI)	**X** No	☐ Yes: $_____
Temporary Assistance for Needy Families (TANF)	**X** No	☐ Yes: $_____
Unemployment Insurance	**X** No	☐ Yes: $_____
VA Non-Service-Connected Disability Pension	**X** No	☐ Yes: $_____
VA Service-Connected Disability Compensation	**X** No	☐ Yes: $_____
Worker's Compensation	**X** No	☐ Yes: $_____

Total Monthly Income $___350_____

ⓘ **Data Entry Tip:** Remember to end date old records and create new records each time a source of income changes.

Non-Cash Benefits

Non-Cash Benefits from Any Source ☐ No **X** Yes ☐ Client doesn't know ☐ Client prefers not to answer

Supplemental Nutrition Assistance Program (SNAP) (Previously known as Food Stamps)	☐ No	**X** Yes
Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	**X** No	☐ Yes
TANF Child Care services	**X** No	☐ Yes
TANF transportation services	**X** No	☐ Yes
Other TANF-funded services	**X** No	☐ Yes
Other (specify): _____	**X** No	☐ Yes

ⓘ HUD requires that the client be asked about each individual source of non-cash benefits and requires an answer be recorded for each.

ⓘ **Data Entry Tip:** Remember to end date old records and create new records each time a source of non-cash benefit changes.

Health

Pregnancy Status **X** No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

If yes, due date _____

Disabilities

ⓘ If one or more of the options below with an asterisk(*) has been selected, the answer to "disabling condition" must be "yes." If none of the answers below with an asterisk(*) has been selected, the answer to "disabling condition" may be "yes" or "no."

Disability type	Disability determination	If yes, expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?
Alcohol Use Disorder	☐ Yes **X** No ☐ DK ☐ PNTA	☐ Yes* ☐ No ☐ DK ☐ PNTA
Both Alcohol and Drug Use Disorders	☐ Yes **X** No ☐ DK ☐ PNTA	☐ Yes* ☐ No ☐ DK ☐ PNTA
Chronic Health Condition	☐ Yes **X** No ☐ DK ☐ PNTA	☐ Yes* ☐ No ☐ DK ☐ PNTA
Developmental Disability	☐ Yes* **X** No ☐ DK ☐ PNTA	*(not applicable)*
Drug Use Disorder	☐ Yes **X** No ☐ DK ☐ PNTA	☐ Yes* ☐ No ☐ DK ☐ PNTA
HIV/AIDS	☐ Yes* **X** No ☐ DK ☐ PNTA	*(not applicable)*
Mental Health Disorder	☐ Yes **X** No ☐ DK ☐ PNTA	☐ Yes* ☐ No ☐ DK ☐ PNTA
Physical Disability	☐ Yes **X** No ☐ DK ☐ PNTA	☐ Yes* ☐ No ☐ DK ☐ PNTA

DK = Client doesn't know; PNTA = Client prefers not to answer

Domestic Violence

ⓘ "Domestic violence" is utilized here as shorthand for 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.

Survivor of Domestic Violence? ☐ No **X** Yes ☐ Client doesn't know ☐ Client prefers not to answer

If yes, when experience occurred	**X** Within the past three months	☐ Three to six months ago
	☐ From six to twelve months ago	☐ More than a year ago
	☐ Client doesn't know	☐ Client prefers not to answer

If yes, currently fleeing? ☐ No **X** Yes ☐ Client doesn't know ☐ Client prefers not to answer

Your client gave updates about their child as well that you need to include in the interim review. Below in red are changes to the child's information at update. Be sure to enter the information listed.

Staff: _____ Project Update Date: **[The 15th of last month]** _ Name of Head of Household: **Jordan [use your last name]**

Project Name (Enter Data As): **[Use SSO project name provided in email as EDA]** _____

Client Record

ⓘ Unless specifically required by a funder, clients may use a preferred name (rather than legal name) for HMIS purposes.

Client **Alex [use your last name]** **[HMIS created and is same as at entry]**
Name Client ID

Client location as of assessment/review date

ⓘ Select the county in which the client is residing (or sleeping at night if unhoused). This field does not need to match the CoC Code above.

Client Location (County) **[no change]**

Housing Move-In Date [Rapid ReHousing projects only]

ⓘ Record the date of the first night the head of household spent living in the unit for permanent housing projects (incl. PSH, RRH, and OPH). This must be on or after the project start date. Leave blank if the client is not yet housed.

Housing Move-In Date **[leave blank for this type of project]**

Health Insurance

Covered by Health Insurance ☐ No **X** Yes ☐ Client doesn't know ☐ Client prefers not to answer

Medicaid (MO HealthNet)	**X** No	☐ Yes
Medicare	**X** No	☐ Yes
State Children's Health Insurance Program	☐ No	**X** Yes
Veteran's Health Administration	**X** No	☐ Yes
Employer-Provided Health Insurance	**X** No	☐ Yes
Health Insurance obtained through COBRA	**X** No	☐ Yes
Private Pay Health Insurance	**X** No	☐ Yes
State Health Insurance for Adults	**X** No	☐ Yes
Indian Health Services Program	**X** No	☐ Yes
Other (specify): _____	**X** No	☐ Yes

ⓘ HUD requires that the client be asked about each individual source of health insurance and requires an answer be recorded for each.

ⓘ **Data Entry Tip:** Remember to end date old records and create new records each time a source of health insurance changes.

Disabilities

ⓘ If one or more of the options below with an asterisk(*) has been selected, the answer to "disabling condition" must be "yes." If none of the answers below with an asterisk(*) has been selected, the answer to "disabling condition" may be "yes" or "no."

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Both Alcohol and Drug Use Disorders	☐ Yes **X** No ☐ DK ☐ PNTA	☐ Yes* ☐ No ☐ DK ☐ PNTA
Chronic Health Condition	☐ Yes **X** No ☐ DK ☐ PNTA	☐ Yes* ☐ No ☐ DK ☐ PNTA
Developmental Disability	☐ Yes* **X** No ☐ DK ☐ PNTA	*(not applicable)*
Drug Use Disorder	☐ Yes **X** No ☐ DK ☐ PNTA	☐ Yes* ☐ No ☐ DK ☐ PNTA
HIV/AIDS	☐ Yes* **X** No ☐ DK ☐ PNTA	*(not applicable)*
Mental Health Disorder	☐ Yes **X** No ☐ DK ☐ PNTA	☐ Yes* ☐ No ☐ DK ☐ PNTA
Physical Disability	☐ Yes **X** No ☐ DK ☐ PNTA	☐ Yes* ☐ No ☐ DK ☐ PNTA

DK = Client doesn't know; PNTA = Client prefers not to answer

Your SSO project provided services at interim update. Please record it on the clients' records using the information below.

Date of service: **The 15th of last month**

Service Type: **RENT PAYMENT ASSISTANCE**

MHDC Payee: XYZ Properties

Monthly Rent Amount: $600

Only answer if your project is funded by MHDC.

Funding Sources: *Pick the correct funding source for your project.**

*If you are unsure what the correct funding source is for your project, please utilize the Funding Source tip sheet available here: http://icamissouri.helpscoutdocs.com/article/116-funding-sources

Amount: $600

Need Status: Closed

Outcome of Need: Fully Met

Date of service: **The 15th of last month**

Service Type: **CASE/CARE MANAGEMENT**

Need Status: Closed

Outcome of Need: Fully Met