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!!!!

					sehold: Jordan [use your last name]			
Project Name (Enter Data As): [Use SSO project name provided in email as EDA]								
Client Record								
① Unless specifically required by a funder, clier	nts may i	ıse a nreferi	red name (rather th	an leg	al name) for HMIS nurnoses			
		se a prefer	<u> </u>		<u> </u>			
Client Jordan [use your last nam Name	<u>e</u>		Client ID	eatec	d and is same as at entry]			
Name			CHETTE					
Client location as of assessment/review d	ate							
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.								
Science the county in which the chefit is residing for sleeping at higher I difficused). This field does not fleed to flatch the Coc Code above.								
Client Location (County) [no change]								
Housing Move-In Date [Rapid ReHousing	project	s only]						
Record the date of the first night the head of h	ousehol	d spent livin	g in the unit for per	mane	nt 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 f	for this	type of	nrojectl					
	OI CIIIS	type or	projecti					
Health Insurance								
Covered by Health Insurance	☐ Client	t doesn't kn	ow   Client pref	fers n	ot to answer			
Medicaid (MO HealthNet)	o <b>X</b> Yes	S						
Medicare X No	X No ☐ Yes HUD requires that the client be asked about							
State Children's Health Insurance Program X No	□ Ye	es 🛈	each individual source of health insurance					
Veteran's Health Administration X No	□ Ye	es	and requires an answer be recorded for each.					
Employer-Provided Health Insurance X No	□ Ye	es						
Health Insurance obtained through COBRA X No	□ Ye	es	Data Entry Tip: Remember to end date old records					
Private Pay Health Insurance X No.	□ Ye	es						
State Health Insurance for Adults X No.	□ Ye	es	and create new re					
Indian Health Services Program X No	□ Ye	es	a source of health insurance changes.					
Other (specify): X No	□ Ye	es						
Monthly Income								
,	Client doe	esn't know	☐ Client prefers	not to	answer			
Alimony and other spousal support	<b>X</b> No							
Child support	X No	☐ Yes: \$			HUD requires that the client be			
Earned income (i.e., employment income)	□ No		350		asked about each individual source			
General Assistance (GA)	<b>X</b> No	☐ Yes: \$	of income and requires an ans be recorded for each.		· ·			
				$\mathbf{\Psi}$	be recorded for each.			
Other (specify):  Pension or retirement income from a former job	X No X No	☐ Yes: \$		$\mathbf{\Phi}$	For any income sources where income is received, the monthly amount must			

☐ Yes: \$

**X** No

Private disability insurance

Retirement Income from Social Securi	ty	<b>X</b> No	☐ Yes: \$						
Social Security Disability Insurance (SS	DI)	<b>X</b> No	☐ Yes: \$				Data Entry	Γin·	
Supplemental Security Income (SSI)		<b>X</b> No	☐ Yes: \$				-	-	ate old records
Temporary Assistance for Needy Fami	lies (TANF)	<b>X</b> No	☐ Yes: \$						rds each time
Unemployment Insurance		<b>X</b> No	☐ Yes: \$				a source of	income c	changes.
VA Non-Service-Connected Disability F	Pension	<b>X</b> No	☐ Yes: \$						
VA Service-Connected Disability Comp	ensation	<b>X</b> No	☐ Yes: \$						
Worker's Compensation		<b>X</b> No	☐ Yes: \$						
Total Monthly Income \$ 350									
Non-Cash Benefits									
Non-Cash Benefits from Any Source	□ No X	Yes 🗆	Client doesn'	t knov	v 🗆 Clier	nt pref	ers not to a	nswer	
Supplemental Nutrition Assistance Pro (Previously known as Food Stamps)	ogram (SNAF	P) □ No	<b>X</b> Yes				at the client n individual		
Special Supplemental Nutrition Progra Women, Infants and Children (WIC)	am for	<b>X</b> No	□ Yes	1			efits and rec corded for e	•	
TANF Child Care services		<b>X</b> No	☐ Yes						
TANF transportation services		X No	☐ Yes		Data Entry	Tip:			
Other TANF-funded services		X No	□ Yes	<b>①</b>	Remember	r to en	d date old r		
Other (specify):		X No	□ Yes		and create new records each time a source of non-cash benefit changes.				
					_ u 50 u. 50 0.			0.10.1.600	
Disabilities  If one or more of the options belo If none of the answers below with									
Disability type	Disability	determina	ation	-	s, expected t tantially imp		_		nd indefinite duration a ndently?
Alcohol Use Disorder	☐ Yes <b>X</b>	No 🗆 D	K □ PNTA			□ Ye	es* □ No	$\square$ DK	□ PNTA
Both Alcohol and Drug Use Disorders	☐ Yes <b>X</b>	No 🗆 D	K □ PNTA			□ Ye	es* □ No	□ DK	□ PNTA
Chronic Health Condition	☐ Yes X	No 🗆 D	K □ PNTA			☐ Ye	es* □ No	$\square$ DK	□ PNTA
Developmental Disability	☐ Yes* X	No 🗆 D	K □ PNTA				(not ap	plicable)	
Drug Use Disorder	☐ Yes X	No 🗆 D	K □ PNTA			☐ Y	es* □ No	$\square$ DK	☐ PNTA
HIV/AIDS	□ Voc* V	🗆 -							
Mental Health Disorder	□ res ∧	.No ⊔ D	K □ PNTA				(not ap	рисавіе)	
Physical Disability			K □ PNTA K □ PNTA			□ Ye			
,	□ Yes <b>X</b>	No □ DI						□ DK	□ PNTA
,	☐ Yes X	No □ DI	K □ PNTA	= Clie	nt prefers no	□ Y	es* □ No es* □ No	□ DK	□ PNTA
·	☐ Yes X ☐ Yes X DK = Clie	No DI No DI ent doesn't	K □ PNTA K □ PNTA t know; PNTA mestic violenc	ce, dat	ing violence	□ Yoot to a	es*	☐ DK ☐ DK	□ PNTA □ PNTA
Domestic Violence  "Domestic violence" is utilized her other dangerous or life-threatening	☐ Yes X ☐ Yes X ☐ He Clie  The as shorthad as conditions	No Dient doesn't	K    PNTA K    PNTA t know; PNTA mestic violence te to violence	ce, dat again	ing violence	☐ Yo ot to a , sexua dual or	es*	□ DK □ DK  alking orember.	□ PNTA □ PNTA
Domestic Violence  "Domestic violence" is utilized her other dangerous or life-threatening	☐ Yes X ☐ Yes X DK = Clie	No Dient doesn't	K □ PNTA K □ PNTA t know; PNTA mestic violenc	ce, dat again	ing violence	☐ Yo ot to a , sexua dual or	es*	□ DK □ DK  alking orember.	□ PNTA □ PNTA
Domestic Violence  "Domestic violence" is utilized her other dangerous or life-threatening.  Survivor of Domestic Violence?	Yes X  Yes X  DK = Clie	No Dient doesn't	K □ PNTA K □ PNTA t know; PNTA mestic violence te to violence ent doesn't ki	ce, dat again now	ing violence st the indivio	☐ Ye ot to a  , sexua dual or  prefer	es*	□ DK □ DK  alking orember.	□ PNTA □ PNTA
Domestic Violence  "Domestic violence" is utilized her other dangerous or life-threatening	Yes X Yes X DK = Clie The as shorthang conditions No X Ye X Within the	No Di No Di ent doesn't and for dor s that relat s Di the past th	K ☐ PNTA K ☐ PNTA t know; PNTA mestic violence te to violence tent doesn't know;	ce, dat again now	ing violence st the indivio Client  Three to six	☐ You to a divide the second of the second	es*	□ DK □ DK  alking orember.	□ PNTA □ PNTA
Domestic Violence  "Domestic violence" is utilized her other dangerous or life-threatening.  Survivor of Domestic Violence?	☐ Yes X ☐ Yes X ☐ Yes X ☐ DK = Clie The as shorthating conditions No X Ye  X Within to ☐ From s	No Di No Di ent doesn't  and for dor s that relat  S Cli  the past th ix to twelv	K  PNTA K  PNTA t know; PNTA mestic violence te to violence ent doesn't know; ree months	ce, dat again now	ing violence, st the individual Client  Three to six  More than	yest to an additional section of the	es* No es* No nswer  al assault, st a family me s not to ans ths ago	□ DK □ DK  alking orember.	□ PNTA □ PNTA
Domestic Violence  "Domestic violence" is utilized her other dangerous or life-threatening.  Survivor of Domestic Violence?	☐ Yes X ☐ Yes X ☐ Yes X ☐ DK = Clie  The as shorthating conditions  No X Ye  X Within to ☐ From s ☐ Client of	No Di No Di ent doesn't and for dor s that relat s Di the past th ix to twelv doesn't know	K  PNTA K  PNTA t know; PNTA mestic violence te to violence ent doesn't know; ree months	ce, dat again now	ing violence st the indivio Client  Three to six	yot to and a sexual or prefer a year ers not	es* No es* No es* No nswer  al assault, st a family me s not to ans ths ago ago to answer	□ DK □ DK  alking orember.	□ PNTA □ PNTA

Your client gave updates abou	ıt their child	d as w	ell tha	t you need to include in the interim review. <mark>Below in</mark>				
red are changes to the child's information at update. Be sure to enter the information listed.								
Staff: Project Update Date: <a href="IThe 15th of last month">[The 15th of last month]</a> Name of Head of Household: <a href="Jordan">Jordan [use your last name]</a> Project Name (Enter Data As): <a href="IUse SSO">[Use SSO</a> project name provided in email as EDA]								
Project Name (Enter Data As): <b>1056 33</b>	O project n	апте р	orovide	u III eilidii ds EDA]				
<u>Client Record</u>								
(i) Unless specifically required by a	funder, clients r	may use	a preferr	ed 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 clier	③ 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) Ino C	hange]							
<u></u>	<u>iiaiigej</u>							
Housing Move-In Date [Rapid Re	Housing pro	jects o	nly]					
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.								
Haveing Mayo In Date								
Housing Move-In Date [lea	ve blank fo	r this t	ype of	project]				
Health Insurance								
Covered by Health Insurance	X Yes 🗆 (	Client do	esn't kno	ow ☐ Client prefers not to answer				
Medicaid (MO HealthNet)	<b>X</b> No	☐ Yes		·				
Medicare	<b>X</b> No	☐ Yes		HUD requires that the client be asked about				
State Children's Health Insurance Progr	ram 🗆 No	<b>X</b> Yes	1	each individual source of health insurance				
Veteran's Health Administration	<b>X</b> No	☐ Yes		and requires an answer be recorded for each.				
Employer-Provided Health Insurance	<b>X</b> No	☐ Yes						
Health Insurance obtained through CO	BRA <b>X</b> No	☐ Yes		Data Falsa Tina				
Private Pay Health Insurance		☐ Yes		Data Entry Tip: Remember to end date old records				
State Health Insurance for Adults		☐ Yes	<b>①</b>	and create new records each time				
Indian Health Services Program		☐ Yes		a source of health insurance changes.				
Other (specify):		☐ Yes						
· · · · · · · · · · · · · · · · · · ·	<del></del>							
<u>Disabilities</u>								
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."								
If yes, expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?								
Alcohol Use Disorder	☐ Yes <b>X</b> No							
Both Alcohol and Drug Use Disorders	☐ Yes <b>X</b> No	□ DK	□ PNTA	☐ Yes* ☐ No ☐ DK ☐ PNTA				
Chronic Health Condition	☐ Yes <b>X</b> No	□DK	□ PNTA	☐ Yes* ☐ No ☐ DK ☐ PNTA				
Developmental Disability	☐ Yes* <b>X</b> No	□ DK	□ PNTA	(not applicable)				
Drug Use Disorder	☐ Yes <b>X</b> No	$\square$ DK	☐ PNTA	☐ Yes* ☐ No ☐ DK ☐ PNTA				
HIV/AIDS	☐ Yes* <b>X</b> No	$\square$ DK	□ PNTA	(not applicable)				
Mental Health Disorder	☐ Yes <b>X</b> No	$\square$ DK	☐ PNTA	☐ Yes* ☐ No ☐ DK ☐ PNTA				
Physical Disability	☐ Yes <b>X</b> No	$\square$ DK	☐ PNTA	☐ Yes* ☐ No ☐ DK ☐ PNTA				
	DK = Client d	oesn't kı	now; PN1	TA = 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