

Client ID: \_\_\_\_\_

Project Name: \_\_\_\_\_

Information Date: \_\_\_\_\_

Staff Name: \_\_\_\_\_

# HMIS Annual/Update Form

For Children in HMIS Projects

Identification – All fields required unless otherwise noted		
First Name: _____	Middle Name: _____	
Last Name: _____	Suffix: _____	
Social Security Number (SSN): _____	_____ - _____ - _____	
Birth Date (DOB): _____/_____/_____	_____ / _____ / _____	
Name of Head of Household: _____	_____	
Assessment Type	<input type="checkbox"/> During Program Enrollment	<input type="checkbox"/> Annual Assessment
Wellness Assessment		
Health Insurance		
<input type="checkbox"/> Yes (Enter Source) <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer		
Health Insurance Source (Check all that apply)		
<input type="checkbox"/> Private Pay Health Insurance	<input type="checkbox"/> Medicare	
<input type="checkbox"/> MEDICAID	<input type="checkbox"/> Health Net (Medi-Cal)-Adults	
<input type="checkbox"/> Health Net (Medi-Cal)-Children	<input type="checkbox"/> State Kaiser (Medi-Cal)-Adults	
<input type="checkbox"/> State Kaiser (Medi-Cal)-Children	<input type="checkbox"/> Health Plan of San Joaquin (Medi-Cal)-Adults	
<input type="checkbox"/> Health Plan of San Joaquin (Medi-Cal)-Children	<input type="checkbox"/> State Children's Health Insurance (Medi-Cal)	
<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"/> State Funded Insurance for Adults (Medi-Cal)	
<input type="checkbox"/> Indian Health Services Program (IHS)	<input type="checkbox"/> Other: _____	
Barriers (For During Program Enrollment Only)		
	Barrier Present	Condition Is Indefinite
<input type="checkbox"/> Alcohol Use Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Chronic Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Developmental Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Client prefers not to answer	
<input type="checkbox"/> Drug Use Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Client Prefers Not to Answer	
<input type="checkbox"/> Mental Health Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Physical Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't know <input type="checkbox"/> Client prefers not to answer