

Agency's LOGO



Head of Household Name: _____

Universal Update Form

Head of Household

HMIS CLIENT ID#

UPDATE DATE

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FILL-IN AFTER SERVICEPOINT ENTRY

MONTH / DAY / YEAR

HOUSEHOLD INFORMATION

Relationship (to HoH)	SELF	Number in Household:	<i>Use a separate HH Member Supplemental page for each additional HH member</i>
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DOMESTIC VIOLENCE

	Client doesn't know	Client refused
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Victim/Survivor (If Yes) how long ago was the last incident? <input type="checkbox"/> Within the past 3 months <input type="checkbox"/> 3-6 months ago <input type="checkbox"/> 6-12 months ago <input type="checkbox"/> More than a year ago <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused (If Yes) are you currently fleeing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Does Not Know <input type="checkbox"/> Client Refused		

LIVING SITUATION

Client Location

Choose the continuum where the client is located (in most cases this will be "IL-514 DuPage")

- | | | |
|---|---|--|
| <input type="checkbox"/> IL-514 DuPage | <input type="checkbox"/> IL-502 Waukegan/North Chicago/Lake | <input type="checkbox"/> IL-512 Bloomington/Central Illinois |
| <input type="checkbox"/> IL-511 SubCook | <input type="checkbox"/> IL-506 Joliet/Kendall/Grundy | <input type="checkbox"/> IL-518 Northwest/LaSalle |
| <input type="checkbox"/> IL-517 Aurora/Elgin/Kane | <input type="checkbox"/> IL-509 De Kalb | |

City and Zip where client stays or spends most of their time

Current City _____ Current Zip _____

Head of Household Name: _____

DISABILITY

Does the client have a disabling condition? *If the disability response changes during program participation contact the HMIS Help Desk for steps on how to complete the update.*

Yes No Doesn't Know Refused

Disability Type	(If Yes) Start Date	Currently receiving Services or Treatment?	Will the Condition be long term?	Disability Determination
Alcohol Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Both Alcohol and Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Chronic Health Condition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Developmental Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Mental Health Problem <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Physical Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			

Head of Household Name: _____

INCOME

Does the household have any current income?

- Yes
 No
 Client Does Not Know
 Client Refused

If No, move on to Household Income for AMI Below:

If Yes, indicate in each source if the household receives the income, and if they do, the household member receiving the income, the monthly amount (to the nearest dollar) of each source, and the income start date.

			HH Member	Amount	Start Date	HH Member	Amount	Start Date
Earned Income								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
				\$			\$	
Unemployment Insurance								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
SSI: Supplemental Security Income								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Social Security Disability Income								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
VA Service Connected								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Private Disability Insurance								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Worker's Compensation								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Temporary Assistance for Needy Families (TANF)								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
General Assistance								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Retirement Income from Social Security								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
VA Non-Service Connected Disability Pension								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Pension or retirement income from another job								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Child Support								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Alimony or Other Spousal Support								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Other Source (specify):								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	

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Head of Household Name: _____

**TOTAL MONTHLY HOUSEHOLD INCOME
FY2017 AREA MEDIAN INCOME (AMI)**

\$ _____

NUMBER OF HOUSEHOLD MEMBERS _____

Household Size	1	2	3	4	5	6	7	8
30% AMI	\$1,563	\$1,783	\$2,008	\$2,229	\$2,408	\$2,588	\$2,767	\$2,946
50% AMI	\$2,600	\$2,971	\$3,342	\$3,713	\$4,013	\$4,308	\$4,604	\$4,904
80% AMI	\$4,163	\$4,754	\$5,350	\$5,942	\$6,421	\$6,896	\$7,371	\$7,846
100% AMI	\$5,200	\$5,942	\$6,683	\$7,425	\$8,025	\$8,617	\$9,208	\$9,808

TOTAL MONTHLY HOUSEHOLD INCOME AS PERCENTAGE OF AMI:

BELOW 30% 30%-49% GREATER THAN 50%

NON-CASH BENEFITS

Does the household currently receive any Non-Cash Benefits?

Yes No Client Does Not Know Client Refused

Please indicate which of the following non-cash benefits have you received over the last 30 days.
(You may use "All" if all household members receive the benefit)

Food stamps or money for food on a benefits card (If yes, amount of benefit)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
TANF child care services	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
TANF transportation services	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Other TANF-Funded Services	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Other Source (specify):	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:

Head of Household Name: _____

HEALTH INSURANCE

Do household members currently have health insurance?

- Yes
 No
 Client Does Not Know
 Client Refused

Complete the following (You may use "All" if all household members receive the benefit)

Medicaid	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Medicare	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Illinois All Kids (State Children's Health Insurance Program)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Veteran's Administration Medical Services	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Employer Provided Health Insurance	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Health Insurance obtained through COBRA	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Private Pay Health Insurance	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
State Health Insurance for Adults	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Indian Health Services Program	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Other	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
If "Yes" to Other, Specify Source:	

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CLIENT'S RESIDENCE/LAST PERMANENT ADDRESS

For SSVF Projects, this is where the client lived for 90 days or more before coming to your project

Client's Street Address				Apt #	
City, Township		State		Zip	
Address Data Quality	<input type="checkbox"/> Full Address Reported <input type="checkbox"/> Client Does Not Know		<input type="checkbox"/> Incomplete or estimated address reported <input type="checkbox"/> Client Refused		
Phone Number		Alternate Phone			
Email Address					
Start Date		End Date			
Client's Residence Notes					
Address Type	<input type="checkbox"/> After Program <input type="checkbox"/> Before Program-Last Permanent		<input type="checkbox"/> Before Program <input type="checkbox"/> Program (while in your project)		

EMERGENCY CONTACT (OPTIONAL)

Contact's Name					
Client's Street Address				Apt #	
City, Township		State		ZIP	
Phone #		Second Phone #			
Relationship to Client					
Start Date		End Date			
Is there a release of information to contact this person?	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Head of Household Name: _____

Universal Update Form

Household Member

HMIS CLIENT ID#	INTAKE/ENTRY DATE

FILL-IN AFTER SERVICEPOINT ENTRY

MONTH / DAY / YEAR

	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>
Domestic Violence Victim/Survivor	(If Yes) how long ago was the last incident? <input type="checkbox"/> Within the past 3 months <input type="checkbox"/> 3-6 months ago <input type="checkbox"/> 6-12 months ago <input type="checkbox"/> More than a year ago <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		
	(If Yes) are you currently fleeing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Does Not Know <input type="checkbox"/> Client Refused		

DISABILITY

Does the client have a disabling condition? *If the disability response changes during program participation contact the HMIS Help Desk for steps on how to complete the update.*

Yes No Doesn't Know Refused

Disability Type	(If Yes) Start Date	Currently receiving Services or Treatment?	Will the Condition be long term?	Disability Determination
Alcohol Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	_____ / _____ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Both Alcohol and Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	_____ / _____ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Chronic Health Condition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	_____ / _____ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Developmental Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	_____ / _____ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			

Head of Household Name: _____

Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	_____ / _____ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	_____ / _____ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Mental Health Problem <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	_____ / _____ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Physical Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	_____ / _____ / _____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			