**NEBRASKA RHY UPDATE**

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| **TYPE OF UPDATE** | | | |
|  | Update |  | Annual Assessment |

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| **DATE OF UPDATE** | | | | | | | | | |
|  |  | **/** |  |  | **/** |  |  |  |  |

Month Day Year

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| **CLIENT NAME** |  | **HMIS CLIENT ID - For HMIS Users only** | | | | | | | | |
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| **ENROLLMENT COC – In which CoC is the Head of Household staying at the time of project entry?** | |
| * NE-500 BOS (Anywhere in Nebraska outside of Lincoln/Omaha) | * NE-502 Lincoln |

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| **INCOME FROM ANY SOURCE – Do the head of household or any adults currently have any income from any source?** | | | | | | | | | | | | |
|  | Yes |  | No |  | Client doesn’t know | | |  | Client prefers not to answer | |  | Data not collected |
| **If “YES” for Income from any Source, indicate all sources and dollar amounts for the source that apply** | | | | | | | | | | | | |
| **Source of Income** | | | | | | **Yes** | **No** | | | **Monthly Amount** | | |
| Earned Income (i.e., employment income) | | | | | |  |  | | | $ | | |
| Unemployment Insurance | | | | | |  |  | | | $ | | |
| Supplemental Security Income (SSI) | | | | | |  |  | | | $ | | |
| Social Security Disability Insurance (SSDI) | | | | | |  |  | | | $ | | |
| VA Service-Connected Disability Compensation | | | | | |  |  | | | $ | | |
| VA Non-Service-Connected Disability Pension | | | | | |  |  | | | $ | | |
| Private Disability Insurance | | | | | |  |  | | | $ | | |
| Worker’s Compensation | | | | | |  |  | | | $ | | |
| Temporary Assistance for Needy Families (TANF) | | | | | |  |  | | | $ | | |
| General Assistance (GA) | | | | | |  |  | | | $ | | |
| Retirement income from Social Security | | | | | |  |  | | | $ | | |
| Pension or retirement income from a former job | | | | | |  |  | | | $ | | |
| Child support | | | | | |  |  | | | $ | | |
| Alimony and other spousal support | | | | | |  |  | | | $ | | |
| Other income source (specify): | | | | | |  |  | | | $ | | |
| **Total monthly income from all sources** | | | | | | | | | | $ | | |

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| **NON-CASH BENEFITS - Do the head of household or any adults receive non-cash benefits from any source?** | | | | | | | | | | | | |
|  | Yes |  | No |  | Client doesn’t know | | |  | Client prefers not to answer |  | Data not collected | |
| **If “YES” for Non-Cash Benefits, indicate all sources that apply** | | | | | | | | | | | | |
|  | Supplemental Nutrition Assistance Program (SNAP)  (Previously known as Food Stamps) | | | | |  | TANF Child Care Services | | | | |
|  | TANF Transportation Services | | | | |
|  | Special Supplemental Nutrition Program for Women,  Infants, and Children (WIC) | | | | |  | Other TANF-funded Services | | | | |
|  | Other Non-Cash Benefit (specify): | | | | |

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| **COVERED BY HEALTH INSURANCE** | | | | | | | | | | | | | | | |
|  | Yes |  | No |  | Client doesn’t know | | |  | Client prefers not to answer | | |  | Data not collected | | |
| **If YES for Covered by Health Insurance, indicate all sources that apply** | | | | | | | | | | | | | | | |
|  | **MEDICAID \*** | | | | |  | Health Insurance obtained through COBRA | | | | | | | | |
|  | MEDICARE | | | | |  | Private Pay Health Insurance | | | | | | | | |
|  | State Children’s Health Insurance Program (SCHIP) | | | | |  | State Health Insurance for Adults | | | | | | | | |
|  | Veteran’s Health Administration (VHA) | | | | |  | Indian Health Services Program | | | | | | | | |
|  | Employer-Provided Health Insurance | | | | |  | Other (specify): | | | | | | | | |
| **\* If you do not have Medicaid, have you applied for Medicaid?** | | | | | | | | | |  | Yes | | |  | No |
| **\* If you have Medicaid or have applied for Medicaid,** may we share your contact information with the Department of Health & Human Services Medicaid and Long-term Care Division so you can receive information about Medicaid from a managed care organization? | | | | | | | | | |  | Yes | | |  | No |

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| **DISABLING CONDITION** | | | | | | | | | | | | | | | | | | |
|  | Yes |  | No | | |  | Client doesn’t know | | | |  | Client prefers not to answer | | | |  | Data not collected | |
| **Answer ‘Yes’ or ‘No’ for each disability type.** If the client selects ‘Yes’ for Physical, Chronic, Mental Health or any of the three Substance Use Disorders, you must also complete the shaded sections below. | | | | | | | | | | | | | | | | | | |
| **Disability Type** | | | | **Yes** | **No** | | | **CDK** | **CPNA** | **DNC** | | | **If Yes: Expected to be of long-continued and**  **indefinite duration and substantially impairs**  **client’s ability to live independently?** | | | | | |
| Physical Disability | | | |  |  | | |  |  |  | | |  Yes |  No |  CDK | |  CPNA |  DNC |
| Developmental Disability | | | |  |  | | |  |  |  | | |  |  |  | |  |  |
| Chronic Health Condition | | | |  |  | | |  |  |  | | |  Yes |  No |  CDK | |  CPNA |  DNC |
| HIV/AIDS | | | |  |  | | |  |  |  | | |  |  |  | |  |  |
| Mental Health Disorder | | | |  |  | | |  |  |  | | |  Yes |  No |  CDK | |  CPNA |  DNC |
| Substance Use Disorder | | | |  |  | | |  |  |  | | |  |  |  | |  |  |
| **If yes for Substance Use Disorder, please indicate:** | | | |  Alcohol use disorder, | | | | | | | | |  Yes |  No |  CDK | |  CPNA |  DNC |
|  Drug use disorder, OR | | | | | | | | |  Yes |  No |  CDK | |  CPNA |  DNC |
|  Both alcohol and drug use disorders | | | | | | | | |  Yes |  No |  CDK | |  CPNA |  DNC |

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| **CURRENT LIVING SITUATION** | | | | | | | | | | | | | | | |
| **Homeless** | |  | Place not meant for habitation (e.g., a vehicle, abandoned building, bus/train station, airport or anywhere outside) | | | | | | | | | | | | |
|  | Emergency shelter, including hotel or motel paid for with emergency shelter voucher, Host Home shelter | | | | | | | | | | | | |
|  | Safe Haven | | | | | | | | | | | | |
| **Institutional** | |  | Foster care home or foster care group home | | | | | | | | | | | | |
|  | Hospital or other residential non-psychiatric medical facility | | | | | | | | | | | | |
|  | Jail, prison, or juvenile detention facility | | | | | | | | | | | | |
|  | Long-term care facility or nursing home | | | | | | | | | | | | |
|  | Psychiatric hospital or other psychiatric facility | | | | | | | | | | | | |
|  | Substance abuse treatment facility or detox center | | | | | | | | | | | | |
| **Temporary Housing** | |  | Transitional housing for homeless persons (including homeless youth) | | | | | | | | | | | | |
|  | Residential project or halfway house with no homeless criteria | | | | | | | | | | | | |
|  | Hotel or motel paid for without emergency shelter voucher | | | | | | | | | | | | |
|  | Host Home (non-crisis) | | | | | | | | | | | | |
|  | Staying or living in a friend’s room, apartment, or house | | | | | | | | | | | | |
|  | Staying or living in a family member’s room, apartment, or house | | | | | | | | | | | | |
| **Permanent Housing** | |  | Rental by client, no ongoing housing subsidy | | | | | | | | | | | | |
|  | Rental by client, with ongoing housing subsidy: | | | | | | | | | | | | |
|  |  GPD TIP housing subsidy | | | | | | | | | | | | |
|  |  VASH housing subsidy | | | | | | | | | | | | |
|  |  RRH or equivalent subsidy | | | | | | | | | | | | |
|  |  HCV voucher (tenant or project based) (not dedicated) | | | | | | | | | | | | |
|  |  Public housing unit | | | | | | | | | | | | |
|  |  Rental by client with other ongoing housing subsidy | | | | | | | | | | | | |
|  |  Housing Stability Voucher | | | | | | | | | | | | |
|  |  Family Unification Program Voucher (FUP) | | | | | | | | | | | | |
|  |  Foster Youth to Independence Initiative (FYI) | | | | | | | | | | | | |
|  |  Permanent Supportive Housing | | | | | | | | | | | | |
|  |  Other permanent housing dedicated for formerly homeless persons | | | | | | | | | | | | |
|  | Owned by client with ongoing housing subsidy | | | | | | | | | | | | |
|  | Owned by client, no ongoing housing subsidy | | | | | | | | | | | | |
| **Other** | |  | Other (specify): | | | | | | | | | | | | |
|  | Worker unable to determine | | | | | | | | | | | | |
|  | Client doesn’t know | | | | | | | | | | | | |
|  | Client prefers not to answer | | | | | | | | | | | | |
|  | Data not collected | | | | | | | | | | | | |
| **Living Situation Verified By:** | | | | | | | | | | | | | | | |
|  | NE-500 Balance of State | | | | |  | | NE-501 Omaha/MACCH | | | |  | NE-502 Lincoln | | |
| **Is client going to have to leave their current living situation within 14 days?** | | | | | | | | | | | | | | | |
|  | Yes | | |  | No | |  | | Client doesn’t know |  | Client prefers not to answer | | |  | Data not collected |
| **Has a subsequent residence been identified?** | | | | | | | | | | | | | | | |
|  | Yes | | |  | No | |  | | Client doesn’t know |  | Client prefers not to answer | | |  | Data not collected |
| **Does individual or family have resources or support networks to obtain other permanent housing?** | | | | | | | | | | | | | | | |
|  | Yes | | |  | No | |  | | Client doesn’t know |  | Client prefers not to answer | | |  | Data not collected |
| **Has the client had a lease or ownership interest in a permanent housing unit in the last 60 days?** | | | | | | | | | | | | | | | |
|  | Yes | | |  | No | |  | | Client doesn’t know |  | Client prefers not to answer | | |  | Data not collected |
| **Has the client moved 2 or more times in the last 60 days?** | | | | | | | | | | | | | | | |
|  | Yes | | |  | No | |  | | Client doesn’t know |  | Client prefers not to answer | | |  | Data not collected |

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| **DATE OF ENGAGEMENT** |  |  | **/** |  |  | **/** |  |  |  |  |
|  | Month | |  | Day | |  | Year | | | |

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| **PREGNANCY STATUS** | | | | | | | | | | | | | | | | | | | |
|  | Yes |  | No |  | Client doesn’t know | |  | | Client prefers not to answer | | | | |  | | Data not collected | | | |
| **IF YES, projected due date?** | | | | | |  | |  | | **/** |  |  | **/** | |  | |  |  |  |
|  | | | | | | Month | | | |  | Day | |  | | Year | | | | |

**UPDATE FOR CHILDREN IN THE HOUSEHOLD**

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| **Last Name** | **First Name** | **MI** | **Suffix** | **\* Use Codes Listed Below \*** | |
| **Health Insurance**  **(all applicable)** | **Disabling Condition**  **(all applicable)** |
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| **Health Insurance:** **CAID**=Medicaid **CARE**=Medicare **SCHIP**=State Children’s Health Insurance Program  **VHA**=Veteran’s Health Administration **EMP**=employer-provided  **COBRA**=health insurance obtained through COBRA **PP**=private pay  **SHIA**=State Health Insurance for Adults **IHSP**=Indian Health Services Program  **N**=no health insurance coverage **DK**=client doesn’t know **PNA**=client prefers not to answer  **OTH**=other (please specify) | | | | | |
| **Disabling Condition: P or PLT**=physical disability or long-term physical disability  **CH or CHLT**=chronic health condition or long-term chronic health condition  **MH or MHLT**=mental health disorder or long-term mental health disorder  **DD**=Developmental Disability **HIV**=HIV/AIDS  **AU or AULT**=alcohol use disorder or long-term alcohol use disorder  **DU or DULT**=Drug use disorder or Long-term drug use disorder  **BO or BOLT**=both alcohol & drug use disorder or long-term alcohol & drug use disorder  **N**=no disabling conditions **DK**=client doesn’t know **PNA**=client prefers not to answer | | | | | |