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Annual Assessment for Permanent Supportive Housing (Adults and Head of Household)
(complete this form for ALL adults)

Client Name: _____ HMIS Client ID#: _____
(optional)
Update/Annual Assessment Date: _____

Client Location: ____ NY-505 (Onondaga/ Cayuga/ Oswego counties)
____ NY-510 (Ithaca/ Tompkins County)

Housing Move In Date: ___/___/___ (Complete for Rapid Re-housing Programs)

Income:
Do you have income? ____Yes ____ No **Total Monthly Income** $_____
Income Source and amount: (please write in the monthly amount below for each source

$_____ Alimony/ Spousal Support
$_____ Child Support
$_____ Earned Income
$_____ General Assistance
$_____ Pension/Retirement income from a job
$_____ Private Disability Insurance
$_____ Retirement Income from Social Security
$_____ Social Security Disability Income (SSDI)
$_____ Social Security Income (SSI)
$_____ Temporary Assist for Needy Families TANF
$_____ Unemployment Insurance
$_____ VA Non-Service-Connected Disability Pension
$_____ VA Service-Connected Disability Compensation
$_____ Worker's Compensation

Non-Cash Benefits:
Do you have Non-Cash Benefits? ____Yes ____ No
Source of Non-Cash Benefits:

_____ Supplemental Nutrition Assistance Program (SNAP) (HUD) (Previously known as Food Stamps)
_____ Special supplemental Nutrition Program for (WIC) (HUD)
_____ TANF Child Care Services (HUD)
_____ TANF Transportation Services (HUD)
_____ Other TANF-Funded Services (HUD); If "Other" Specify: _____

Medical Insurance:
Do you have Health Insurance/ Medical Assistance? ____Yes ____ No
Source of Health Insurance/ Medical Assistance:

_____ Medicaid _____ Medicare
_____ State Children's Health Insurance Program
_____ Veteran's Administration (VA) Medical Services
_____ Employer – Provided Health Insurance
_____ Health Insurance obtained through COBRA
_____ State Health Insurance for Adults
_____ Indian Health Care _____ Other

Medicaid ID# _____
Medicaid Insurance Company: ____ Total Care ____ Blue Cross Blue Shield ____ Fidelis
____ United Healthcare ____ Molina Healthcare

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Disabling Condition:

Do you have a disability of long duration? ____Yes ____ No

For each disability, check "LCI" if it is expected to be of long, continued and indefinite duration, substantially impairs the individual's ability to live independently, and is of such a nature that such ability could be improved by more suitable housing conditions.

Disability Type:

__Yes __LCI Alcohol Use Disorder __Yes__LCI BOTH Alcohol & Drug Use Disorder __Yes__LCI Drug Use Disorder
__Yes__LCI Chronic Health Condition __Yes__LCI Developmental _____ HIV/AIDS
__Yes__LCI Mental Health Disorder __Yes__LCI Physical Health

Well-being Assessment: Information Date: ____/____/_____

Client Perceives their life has value and worth.

____ Strongly disagree ____ Somewhat disagree ____ Neither agree nor disagree ____ Somewhat agree ____ Strongly agree

Client Perceives they have support from others who will listen to problems.

____ Strongly disagree ____ Somewhat disagree ____ Neither agree nor disagree ____ Somewhat agree ____ Strongly agree

Client perceives they have a tendency to bounce back after hard times.

____ Strongly disagree ____ Somewhat disagree ____ Neither agree nor disagree ____ Somewhat agree ____ Strongly agree

Client's frequency of feeling nervous, tense, worried, frustrated, or afraid.

____ One-time event
____ Once a Week ____ Twice a Week ____ Three Times a Week ____ Four or more times a Week
____ Once a Month ____Twice a Month ____ Three Times a Month ____ Four Times a Month