CNYHMIS Annual Assessment for Adults and Head of Household
(complete this form for ALL adults)

Client Name: ________________________________
HMIS Client ID#: ____________________________

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
$_____ Earned Income
$_____ Pension/Retirement income from a job
$_____ Retirement Income from Social Security
$_____ Social Security Income (SSDI)
$_____ Unemployment Insurance
$_____ VA Service-Connected Disability Compensation
$_____ VA Non-Service-Connected Disability Pension

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

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
- [ ] Yes __LCI__ HIV/AIDS
- [ ] Yes __LCI__ Mental Health Disorder
- [ ] Yes __LCI__ Physical Health

**Current Living Situation:**
**Street Outreach ONLY**

Start Date: ___/___/_____
End Date: ___/___/_____
Information Date: ___/___/_____

Current Living Situation:

- [ ] Homeless Situation (chose only one):
  - [ ] Place not meant for human habitation
  - [ ] Emergency shelter, including hotel or motel paid for with emergency shelter voucher
  - [ ] Safe Haven
  - [ ] Interim Housing

Institutional Situation:

- [ ] Foster care home/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/detox center

Transitional and Permanent Housing Situation:

- [ ] Hotel or motel paid without emergency voucher
- [ ] Owned by client, no on-going housing subsidy
- [ ] Owned by client, with on-going housing subsidy
- [ ] Permanent housing (other than RRH) for formerly homeless persons
- [ ] Rental by client, no ongoing housing subsidy
- [ ] Rental by client, with VASH Subsidy
- [ ] Rental by client, with GPD TIP subsidy
- [ ] Rental by client, with other ongoing housing subsidy
- [ ] Residential project or halfway house with no homeless criteria
- [ ] Staying in family member’s room/apartment/house
- [ ] Staying in friend’s room/apartment/house
- [ ] Transitional housing for homeless persons (including homeless youth)

Other:
- [ ] Other: Specify _______________________________________________________
- [ ] Worker Unable to Determine

Living Situation verified by: (Agency/ Program Name): ____________________________________________
Is Client Going to have to leave their current living situation within 14 days?  ____Yes ____ No

If “Yes” to ‘Is client going to have to leave their current living situation within 14 days?’ answer the following questions:
  Has a subsequent residence been identified?  ____Yes ____ No
  Does individual or family have resources or support networks to obtain other permanent housing?  
    ____Yes ____ No
  Has the client had a lease or ownership interest in a permanent housing unit in the last 60 days?  
    ____Yes ____ No
  Has the client moved 2 or more times in the last 60 days?  ____Yes ____ No

Location details:  

______________________________  
______________________________

Date of Engagement:  ____/____/______

(Complete upon client entering Service Plan development or fully completed initial assessment)