Housing & Homeless Coalition
Of Central New York

www.hhccny.org
housingandhomelesscoalition@gmail.com
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315-428-2216

CNYHMIS Annual Assessment for 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

Disabling Condition:
Do you have a DISABILITY of long duration? ____Yes ____ No

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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

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): _____

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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)