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
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