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:

<table>
<thead>
<tr>
<th>Income Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>$_____ Alimony/ Spousal Support</td>
<td></td>
</tr>
<tr>
<td>$_____ Earned Income</td>
<td></td>
</tr>
<tr>
<td>$_____ Pension/Retirement income</td>
<td></td>
</tr>
<tr>
<td>$_____ Retirement Income from Social Security</td>
<td></td>
</tr>
<tr>
<td>$_____ Social Security Income (SSI)</td>
<td></td>
</tr>
<tr>
<td>$_____ Unemployment Insurance</td>
<td></td>
</tr>
<tr>
<td>$_____ VA Service-Connected Disability Compensation</td>
<td></td>
</tr>
</tbody>
</table>

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  _____ Other
- _____ 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
If yes, do you have determination of Disability?  ____Yes  ____No
If yes, are you currently receiving treatment for Disability?  ____Yes  ____No

Disability Type:
- [ ] Alcohol Use
- [ ] BOTH Alcohol & Drug Use
- [ ] Drug Use
- [ ] Chronic Health Condition
- [ ] Developmental
- [ ] HIV/AIDS
- [ ] Mental Health Disorder
- [ ] Physical Health