Housing & Homeless Coalition
Of Central New York

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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:

$_____ 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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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	