Homeless Resource Council of the Sierras — HMIS Annual Assessment Form

Annual Assessment Summary *Annual Assessment MUST be completed within +/- 30 days of Project Entry Date anniversary.*

Project Assessment Date: _____/_____/_____ **Intake Staff Name:** _____

Project Name: _____ **HMIS Client ID** (Must have an ID)**:** _____

Basic Client Profile (Universal Data Elements)

Name (First, Middle, Last)		**Date of Birth**	_____/_____/_____

Detailed Client Information (Program-Level Data Elements)

Income Received from Any Source	☐Yes ☐No ☐Client Doesn't Know ☐Client Refused

If yes, indicate all sources and dollar amounts for applicable sources

Source of Income	**Receiving?**	**Amount**
Earned Income	☐Yes ☐No	$.
Unemployment Insurance	☐Yes ☐No	$.
Supplemental Security Income (SSI)	☐Yes ☐No	$.
Social Security Disability Insurance (SSDI)	☐Yes ☐No	$.
VA Service – Connected Disability Compensation	☐Yes ☐No	$.
VA Non-Service Connected Disability Pension	☐Yes ☐No	$.
Private Disability Insurance	☐Yes ☐No	$.
Workers' Compensation	☐Yes ☐No	$.
Temporary Assistance for Needy Families (TANF)	☐Yes ☐No	$.
General Assistance (GA)	☐Yes ☐No	$.
Retirement Income from Social Security	☐Yes ☐No	$.
Pension/Retirement from a former job	☐Yes ☐No	$.
Child Support	☐Yes ☐No	$.
Alimony/Spousal Support	☐Yes ☐No	$.
Other: _____	☐Yes ☐No	$.
Total *Monthly* Income		$.

Non-Cash Benefits Received	☐Yes ☐No ☐Client Doesn't Know ☐Client Refused

If yes, indicate all sources that apply

Source of Non-Cash Benefit	**Yes**	**No**
Supplemental Nutritional Assistance Program (SNAP) (CalFresh or "Food Stamps")	☐	☐
Special Supplementation Nutritional Program for (WIC)	☐	☐
TANF Child Care Services	☐	☐
TANF Transportation Services	☐	☐
Other TANF-Funded Services	☐	☐
Other:_____	☐	☐

Covered by Health Insurance	☐Yes ☐No ☐Client Doesn't Know ☐Client Refused

If yes, indicate all sources that apply

Source of Insurance	**Yes**	**No**
MEDICAID (Medi-Cal)	☐	☐
MEDICARE	☐	☐
State Children Health Insurance Program	☐	☐
VA Medical Services	☐	☐
Employer Provided Health Insurance	☐	☐
Health Insurance obtained through COBRA	☐	☐
Private Pay Health Insurance	☐	☐
State Health Insurance for Adults	☐	☐
Indian Health Services Program	☐	☐
Other: _____	☐	☐

Physical Disability *If Yes, expected to be of long-continued/indefinite duration; substantially impairs ability to live independently.*	☐Yes ☐Client Doesn't Know ☐No ☐Client Refused ☐Yes ☐Client Doesn't Know ☐No ☐Client Refused	**Developmental Disability** *If Yes, expected to be of long-continued/indefinite duration; substantially impairs ability to live independently.*	☐Yes ☐Client Doesn't Know ☐No ☐Client Refused ☐Yes ☐Client Doesn't Know ☐No ☐Client Refused
Chronic Health Condition *If Yes, expected to be of long-continued/indefinite duration; substantially impairs ability to live independently.*	☐Yes ☐Client Doesn't Know ☐No ☐Client Refused ☐Yes ☐Client Doesn't Know ☐No ☐Client Refused	**HIV/AIDS** *If Yes, expected to substantially impairs ability to live independently.*	☐Yes ☐Client Doesn't Know ☐No ☐Client Refused ☐Yes ☐Client Doesn't Know ☐No ☐Client Refused
Mental Health Problem *If Yes, expected to be of long-continued/indefinite duration; substantially impairs ability to live independently.*	☐Yes ☐Client Doesn't Know ☐No ☐Client Refused ☐Yes ☐Client Doesn't Know ☐No ☐Client Refused	**Substance Abuse Problem** *If Yes, expected to be of long-continued/indefinite duration; substantially impairs ability to live independently.*	☐Alcohol Abuse ☐Drug Abuse ☐Both Alcohol & Drug Abuse ☐No ☐Client Doesn't Know ☐Client Refused ☐Yes ☐Client Doesn't Know ☐No ☐Client Refused

Domestic Violence Victim/Survivor	☐Yes ☐No ☐Client Doesn't Know ☐Client Refused	*If Yes, when experience occurred?* *If yes, are you currently fleeing?*	☐Within past three months ☐Client Doesn't Know ☐Three to six months ago ☐Client Refused ☐Six to twelve months ago ☐More than a year ago ☐Yes ☐Client Doesn't Know ☐No ☐Client Refused

Client Locations	**CA-515**

Street Outreach/Night by Night Shelter Stays/PATH Street Outreach Only			
Contact Date	_____/_____/_____	**Staying on Streets, in ES, or SH**	☐Yes ☐No ☐Worker unable to determine
Date of Engagement	_____/_____/_____		

Permanent Housing Projects Only (RRH and PSH Only)	
Housing Move-In Date	_____/_____/_____

PATH Projects Only			
PATH Status			
Client became enrolled in PATH	☐Yes ☐No	*IF no, reason not enrolled*	☐Client was found ineligible for PATH ☐Client was not enrolled for other reason(s)
Date of Determination		_____/_____/_____	

Connection with SOAR	☐Yes ☐No