COC HMIS DATA FOR ANNUAL PROGRAM ASSESSMENT--ADULT

Respond to the following questions for the head of household and each additional adult in the household. A separate form should be included for each adult member of the household.

Assessment Date (e.g., 09/20/2023)

The Assessment Date will serve as the information date for all data elements collected on this form; all data must be accurate as of this date, regardless of the date collected.

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Month Day Year

CLIENT (name or other identifier)

DOMESTIC VIOLENCE

Is client a domestic violence victim/survivor?

- ☐ No
- ☐ Yes
- ☐ Client doesn't know
- ☐ Client Prefers Not to Answer

[IF YES] When did the experience occur?

- ☐ Within the past three months
- ☐ Three to six months ago (excluding six months exactly)
- ☐ Six months to one year ago (excluding one year exactly)
- ☐ One year ago or more
- ☐ Client doesn't know
- ☐ Client Prefers Not to Answer

[IF YES] Are you currently fleeing?

- ☐ No
- ☐ Yes
- ☐ Client doesn't know
- ☐ Client Prefers Not to Answer

NON-CASH BENEFITS

No	Yes	Source of Non Cash Benefit		No	Yes	Source of Non Cash Benefit
☐	☐	Supplemental Nutrition Assistance Program (SNAP)		☐	☐	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
☐	☐	TANF Child Care services		☐	☐	TANF transportation services
☐	☐	Other TANF-Funded Services		☐	☐	Section 8, Public Housing, or other ongoing rental assistance
☐	☐	Temporary rental assistance		☐	☐	Other:

DISABLING CONDITIONS

No	Yes	Type of Disability		Is the disability long term & impairs the clients ability to live independently? No	Yes
☐	☐	Alcohol Abuse	If yes ☞	☐	☐
☐	☐	Drug Abuse		☐	☐
☐	☐	Both Alcohol & Drug		☐	☐
☐	☐	Mental Health		☐	☐
☐	☐	Developmental		☐	☐
☐	☐	Chronic Health		☐	☐
☐	☐	HIV/AIDS		☐	☐
☐	☐	Physical		☐	☐

PATH ONLY----

Connection with SOAR:

☐	No	☐	Client doesn't know
☐	Yes	☐	Client Prefers Not to Answer

INCOME AND SOURCES

No	Yes	Source of Income	Monthly Amount		No	Yes	Source of Income	Monthly Amount
☐	☐	Earned income	$		☐	☐	Temporary Assistance for Needy Families (TANF)	$
☐	☐	Unemployment Insurance	$		☐	☐	General Assistance (GA)	$
☐	☐	Supplemental Security Income (SSI)	$		☐	☐	Retirement Income from Social Security	$
☐	☐	Social Security Disability Income (SSDI)	$		☐	☐	Pension or retirement income from a former job	$
☐	☐	VA Service-Connected Disability Compensation	$		☐	☐	Child support	$
☐	☐	VA Non-Service-Connected Disability Pension	$		☐	☐	Alimony or other spousal support	$
☐	☐	Private disability insurance	$		☐	☐	Other source:	$
☐	☐	Worker's Compensation	$		☐	☐	VA Non-Service-Connected Disability Pension	**$**

Total Monthly Amount $_______________

HEALTH INSURANCE

No	Yes	Source of Health Insurance		No	Yes	Source of Health Insurance
☐	☐	Medicaid		☐	☐	Medicare
☐	☐	State Children's Health Insurance Program		☐	☐	Veteran's Administration (VA) Medical Services
☐	☐	Employer-Provided Health Insurance		☐	☐	Health insurance obtained through COBRA
☐	☐	Private Pay Health Insurance		☐	☐	State Health Insurance for Adults
☐	☐	Indian Health Services		☐	☐	Other:______________________

LEGAL INFORMATION
Upcoming Court Dates? ☐ Yes ☐ No
Please explain any current legal issues you are experiece____ ____ ____

Client Verification

I certify that the information provided by me on this assessment, as well as information provided by me regarding the income and assets of members of my family unit, is true to the best of my knowledge. I hereby promise to report any changes in this information that may occur while my case is open.

Client's Name ____

Client's Signature ____

Date_____/_____/_____