HMIS Interim (Annual Assessment) Form for CoC and ESG Projects

Effective 10/1/2021

Intake Date MM/DD/YYYY

Entry Date MM/DD/YYYY

ServicePoint (HoH) ID:

Project Name

HoH First Name

Middle

Last

Suffix

Alias

☐ Full Name Reported

☐ Partial, Street or Code Name

☐ Client doesn't know

☐ Client Refused

Social Security Number:

☐ Full SSN reported

☐ Approx or Partial SSN

☐ Client doesn't know

☐ Client refused

Date of Birth: MM/DD/YYYY

☐ Full DOB reported

☐ Approx or Partial DOB

☐ Client doesn't know

☐ Client refused

Race (Select all that apply)

☐ American Indian, Alaska Native or Indigenous

☐ Native Hawaiian or Pacific Islander

☐ Asian or Asian American

☐ White

☐ Black, African American or African

☐ Client doesn't know

☐ Client refused

Gender

☐ Female

☐ Male

☐ A gender other than singulary female or male (e.g., non-binary, genderfluid, agender, culturally specific gender)

☐ Transgender

☐ Questioning

☐ Client doesn't know

☐ Client refused

Ethnicity

☐ Non-Hispanic/Non-Latino(a)(o)(x)

☐ Hispanic/Latino(a)(o)(x)

☐ Client doesn't know

☐ Client refused

Veteran Status

☐ No

☐ Yes

Relationship to Head of Household (Must be an adult)

☐ Self (Head of Household)

☐ HoH's child

☐ HoH's spouse or partner

☐ HoH's other relation member

☐ Other: non-relation member

Note: Data on this page can help to update missing info on the client's HMIS Entry Assessment and Client Profile tab.

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Housing Move-in Date (answer only if client is in an RRH, PH or PSH HMIS Project)	☐☐/☐☐/☐☐
Client Location CoC Code (Must be KY501 if served in Louisville/Jefferson Co)	_____
Date of Engagement (for Outreach, Emergency Shelter & Supportive Services Only Projects)	☐☐/☐☐/☐☐

Health Insurance

☐ No
☐ Yes (identify source below)
☐ Client doesn't know
☐ Client

Source:

☐ Medicaid
☐ State Children's Health Insurance (KCHIP)
☐ Employer-Provided Health Insurance
☐ Private Pay Health Insurance
☐ Indian Health Services Program
☐ Medicare
☐ VA Medical Services
☐ Health Insurance obtained through COBRA
☐ State Health Insurance for Adults
☐ Other: _____

Disability

Do you have a physical, mental or emotional Impairment, a post-traumatic stress disorder, or brain injury; a development disability, HIV/AIDS, or a diagnosable substance abuse problem?

☐ No ☐ Yes (indicate type(s) below) ☐ Client doesn't know ☐ Client refused

	Physical ☐	**Mental Health** ☐	**Chronic Health Condition** ☐	**☐ Alcohol ☐ Drugs ☐ Both**	**Developmental** ☐	**HIV/AIDS** ☐
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

**Only answer the following questions for Adults and HoH. **

Income

☐ No/None at all ☐ Yes (identify source and amounts)
☐ Client doesn't know ☐ Client refused

Source:	**Amount:**
☐ Earned income (i.e., employment income)	$_____. 00
☐ Unemployment Insurance	$_____. 00
☐ Supplemental Security Income (SSI)	$_____. 00
☐ Social Security Disability Income (SSDI)	$_____. 00
☐ Retirement Income from Social Security	$_____. 00
☐ VA Service-Connected Disability Compensation	$_____. 00
☐ VA Non-Service-Connected Disability Pension	$_____. 00
☐ Worker's Compensation	$_____. 00
☐ Temporary Assistance for Needy Families (TANF)	$_____. 00
☐ General Assistance (GA)	$_____. 00

☐ Private disability Insurance	$_____. 00
☐ Pension or retirement income from a former job	$_____. 00
☐ Child Support	$_____. 00
☐ Alimony or other spousal support	$_____. 00
☐ Other source: _____	$_____. 00
Total Monthly Income:	**$**

Non-Cash Benefits

☐ No/None at all ☐ Yes (Identify source below)
☐ Client doesn't know ☐ Client refused

Source:

☐ 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
☐ Other: _____

Domestic Violence

Are you, or have you been a survivor of domestic or intimate partner violence?
☐ No ☐ Yes ☐ Client doesn't know ☐ Client refused

If YES, how long ago did you have this experience?
☐ Within the past 3 months ☐ 1 year ago or more
☐ 3 to 6 months ago ☐ 6 months to 1 year ago
☐ Client doesn't know ☐ Client refused

If Yes, are you currently fleeing?
☐ No ☐ Yes
☐ Client doesn't know ☐ Client refused

Foster Care	Zip Code of Last Permanent Address
☐ Yes ☐ No	☐☐☐☐☐

Staff Completing (Printed Name): **Date:**
