Housing & Homeless Coalition
Of Central New York

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315-428-2216

# PATH Annual Assessment for SSO

***Answer the following questions for ALL Adults and HoH***

**Client Name:** _____
Annual Assessment Date: _____

***The following questions should be asked and updated for every new entry into housing:***

***Disabling Condition:***

**Do you have a DISABILITY of long duration?** ____Yes ____ No

For each disability, check "LCI" if it is expected to be of long, continued and indefinite duration, substantially impairs the individual's ability to live independently, and is of such a nature that such ability could be improved by more suitable housing conditions.

**Disability Type:**

__Yes __LCI Alcohol Use Disorder __Yes__LCI BOTH Alcohol & Drug Use Disorder __Yes__LCI Drug Use Disorder
__Yes__LCI Chronic Health Condition __Yes__LCI Developmental _____ HIV/AIDS
__Yes__LCI Mental Health Disorder __Yes__LCI Physical Health

**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 Health Administration (VHA)
_____ 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

**Income:**

**Do you have income?** ____Yes ____ No **Total Monthly Income** $_____

Income Source and amount: (please write in monthly amount for each source below)

_____ Alimony/ Spousal Support _____ Child Support
_____ Earned Income _____ General Assistance
_____ Pension or retirement income from another 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 **Monthly Amount** $_____

Source of Non-Case Benefits:

_____ Supplemental Nutrition Assistance Program (SNAP) (HUD) (Previously known as Food Stamps)
_____ Special supplemental Nutrition Program for (WIC) (HUD)

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_____ TANF Child Care Services (HUD)
_____ TANF Transportation Services (HUD)
_____ Other TANF-Funded Services (HUD); If "Other" Specify: _____

**Date of Engagement: ___/___/___** (Complete upon client entering Service Plan development or fully completed initial assessment)

**Connection to SOAR: ____Yes ____ No**

**Personal Phone Number: _____ - _____ - _____**