



www.hhccny.org  
housingandhomelesscoalition@gmail.com  
@hhcofcny facebook.com/hhccny  
315-428-2216

**FY 2024 CNYHMIS Annual Assessment for Adults and Head of Household - RRH**

(complete this form for ALL adults)

**Client Name:** \_\_\_\_\_ **HMIS Client ID#:** \_\_\_\_\_ (optional)  
**Update/Annual Assessment Date:** \_\_\_\_\_

**Head of Household ONLY:**

**Housing Move In Date:** \_\_\_/\_\_\_/\_\_\_ (Complete for Rapid Re-housing Programs)

**Answer for all adults and head of households:**

**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 the monthly amount below for each source)

\$ ___ 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



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**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: \_\_\_\_\_

**Are you a Survivor of Domestic Violence?** \_\_\_ Yes \_\_\_ No

**If yes, when did it last occur:** \_\_\_ Within the past 3 months \_\_\_ 3 to 6 months \_\_\_ 6 to 12 months

\_\_\_ More than 12 months \_\_\_ Refused

**Are you currently fleeing?** \_\_\_ Yes \_\_\_ No

**Personal Phone Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_