www.hhccny.org
hhc@unitedway-cny.org
facebook.com/hhccny
hhcofcny

FY2024 CNYHMIS VA SSVF Update/Annual Assessment for HP and RRH (complete this form for ALL adults)

Client Name: _____
Update/ Annual Assessment Date: _____

Head of Household ONLY:

Housing Move In Date: ___/___/___ (Complete for Rapid Re-housing Programs)

Answer the following for ALL Clients:

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: (Ask about each source individually, and please write in the monthly amount below for each source)

$_____ 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

www.hhccny.org
hhc@unitedway-cny.org
facebook.com/hhccny
hhcofcny

$_____ 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-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

Connection to SOAR? ____Yes ____ No