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CNY HMIS YHDP Entry Assessment (Child of Parenting Youth)

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

Pregnant? Yes No If yes, Projected Birth Date: ____/____/____

Personal Phone Number: _____ - _____ - _____