A Tradition of Stewardship
A Commitment to Service

Napa County Continuum of Care

HMIS Status or Annual Assessment Form

For HMIS Staff ONLY
Is this the HoH? ☐ Yes ☐No
If no, client's HMIS ID of HoH: _____
Data entered in HMIS on _____ by _____

Program(s) Name: _____ Case Worker/Intake Person: _____ Date of Status or Annual Assessment: _____

CLIENT PROFILE

First Name: _____ **Middle Name:** _____ **Last Name:** _____

Social Security No. _____ **Birth Date:** _____

STATUS OR ANNUAL ASSESSMENT QUESTIONS

Complete Housing Move-In Date When Client Moves Into a Permanent Housing Unit (RRH, PH, PSH)

Housing Move-In Date: _____ REQUIRED for RRH, PSH, PH Projects

Disabling Conditions and Barriers

A disabling condition is one or more of the following:

Physical Disability ☐ Yes ☐No ☐Client Doesn't Know ☐Refused ☐Data not collected
If yes, does Physical Disability expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? ☐ Yes ☐No ☐Client Doesn't Know ☐Refused ☐Data not collected

Developmental Disability ☐ Yes ☐No ☐Client Doesn't Know ☐Refused ☐Data not collected
If yes, does Developmental Disability substantially impair ability to live independently?
☐ Yes ☐No ☐Client Doesn't Know ☐Refused ☐Data not collected

Chronic Health Condition ☐ Yes ☐No ☐Client Doesn't Know ☐Refused ☐Data not collected
If yes, does Chronic Health expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? ☐ Yes ☐No ☐Client Doesn't Know ☐Refused ☐Data not collected

HIV - AIDS ☐ Yes ☐No ☐Client Doesn't Know ☐Refused ☐Data not collected
If yes, does HIV-AIDS substantially impair ability to live independently?
☐ Yes ☐No ☐Client Doesn't Know ☐Refused ☐Data not collected

Mental Health Problem ☐ Yes ☐No ☐Client Doesn't Know ☐Refused ☐Data not collected
If yes, does Mental Health expected to be of long-continued and indefinite duration and substantially impair ability to live independently? ☐ Yes ☐No ☐Client Doesn't Know ☐Refused ☐Data not collected

Substance Abuse Problem ☐No ☐Alcohol Abuse ☐Drug Abuse ☐Both Alcohol and Drug Abuse
☐Client Doesn't Know ☐Refused ☐Data not collected
If yes, does Substance Abuse Problem expected to be of long-continued and indefinite duration and substantially impedes ability to live independently? ☐ Yes ☐No ☐Client Doesn't Know ☐Refused ☐Data not collected

If Client answered yes to any of the above, then following question needs to be YES
Does client have a disabling condition? ☐ Yes ☐No

Is Client a Domestic Violence Victim/Survivor? ☐ Yes ☐No ☐Client Doesn't Know ☐Refused ☐Data not collected
If yes, last occurrence? ☐Within the past 3 months ☐3-6 months ago ☐6-12 months ago ☐One year ago or more
☐Client Doesn't Know ☐Refused ☐Data not collected
Is client currently fleeing? ☐ Yes ☐No ☐Client Doesn't Know ☐Refused ☐Data not collected

Monthly Cash Income for Individual

Does Client Receive any Income from Any Source? ☐ Yes ☐No ☐Client Doesn't Know ☐Refused ☐Data not collected

If yes, please mark one below and enter amount:

☐Earned Income $ _____
☐Child Support $ _____
☐General Assistance $ _____
☐TANF/CalWorks $ _____
☐Private Disability Insurance $ _____
☐Retirement from Social Security $_____
☐Pension from a Former Job $ _____
☐Other Income $ _____ Source: _____
☐Social Security Disability Income (SSDI) $ _____
☐Social Security Income (SSI) $ _____
☐Spousal Support $ _____
☐Unemployment Insurance $ _____
☐ VA Service-Connected Disability Compensation $ _____
☐ VA Non-Service Connected Disability Compensation $ ____
☐Worker's Compensation $ _____

Non-Cash Benefits

Does Client Receive Non-Cash Benefits from Any Source?

☐ Yes ☐No ☐Client Doesn't Know ☐Refused ☐Data not collected

If yes, please mark one below:

☐CalFresh (Food Stamps/SNAP)
☐TANF/CalWorks Childcare Services
☐WIC (Supplemental Nutrition for Women, Infants, and Children)
☐ TANF/CalWorks Transportation Services
☐ Other TANF/CalWorks-Funded Services
☐ Other Non-Cash Benefits – Source: _____

Health Insurance

Health Insurance from Any Source? ☐ Yes ☐No ☐Client Doesn't Know ☐Refused ☐Data not collected

If yes, please mark one below:

☐Employer Provided
☐Healthy Kids (CHI) (State Children's HIP)
☐Indian Health Services Program
☐Medical/Medicaid
☐Medicare
☐ Obtained through COBRA
☐ Private Pay Health Insurance
☐ State Health Insurance for Adults
☐ Veteran Administration (VA) Medical Services
☐ Other: Specify _____

Status Assessment - To be filled out <u>every time there is a change</u> in disabilities, income, non-cash benefits or health insurance.

Annual Assessment – To be filled out <u>once a year</u> - 30 days before/after anniversary start date.