Colorado HMIS Annual Assessment Adult/Family (07/24/2015)

Fill out a separate form for each adult household member. Children can be included on head of household.

(FOR AGENCY USE ONLY)

Program Assessment Date:_____ /_____/_____ Program Name/Grant:_____

GENERAL INFORMATION

First Name: _____ Middle Name: _____

Last Name: _____ Suffix: _____

Current Address

Address: _____ Unit#:_____

City:_____ State/Province: _____ Zip Code: _____

INCOME & BENEFITS

Please take a new snapshot in HMIS, ensuring the date matches the assessment interview date, and update income & benefits information.

Monthly Income Source (*Choose all that applies*)	Stated Income	Documentation
❑ No Financial Resources		
❑ Earned Income (i.e. employment income)	$_____	
❑ Unemployment Insurance	$_____	
❑ Supplemental Security Income (SSI)	$_____	
❑ Social Security Disability Income (SSDI)	$_____	
❑ Veteran's Service-Connected Disability Compensation	$_____	
❑ Veteran's Non-Service-Connected Disability Compensation	$_____	
❑ Private Disability Insurance	$_____	
❑ Worker's Compensation	$_____	
❑ Temporary Assistance for Needy Families (TANF)	$_____	
❑ General Assistance (GA)	$_____	
❑ Retirement Income from Social Security	$_____	
❑ Pension from Former Job	$_____	
❑ Child Support	$_____	
❑ Alimony/Other Spousal Support	$_____	
❑ Aid to the Needy and Disabled (AND)	$_____	
❑ Old Age Pension (OAP)	$_____	
❑ Other Sources	$_____	
❑ Client Doesn't Know ❑ Client Refused		

Non-Cash Benefits (*Choose all that applies*)

❑ None ❑ Client Doesn't Know ❑ Client Refused ❑ Other Benefit Source:_____

❑ Food Stamps/SNAP_$_____ (amount optional) ❑ TANF Child Care ❑ Temporary Rental Assistance

❑ TANF Transportation Services ❑ Section 8 or Rental Assistance

❑ WIC (Women, Infants and Children) ❑ Other TANF-funded Services

Health Insurance

❑ No Health Insurance ❑ Client Doesn't Know ❑ Client Refused ❑ Other_____

❑ MEDICAID ❑ MEDICARE ❑ State Children's Health Insurance ❑ Veteran's - VA Medical Services

❑ Employer provided Health Insurance ❑ COBRA ❑ Private Pay Health Insurance ❑ State Adult Health Insurance

General Information – Child 1

First Name: _____ Middle Name: _____

Last Name: _____ Suffix: _____

Health Insurance			
❑ No Health Insurance	❑ Client Doesn't Know	❑ Client Refused	❑ Other_____
❑ MEDICAID	❑ MEDICARE	❑ State Children's Health Insurance	❑ Veteran's - VA Medical Services
❑ Employer provided Health Insurance	❑ COBRA	❑ Private Pay Health Insurance	❑ State Adult Health Insurance

General Information – Child 2

First Name: _____ Middle Name: _____

Last Name: _____ Suffix: _____

Health Insurance			
❑ No Health Insurance	❑ Client Doesn't Know	❑ Client Refused	❑ Other_____
❑ MEDICAID	❑ MEDICARE	❑ State Children's Health Insurance	❑ Veteran's - VA Medical Services
❑ Employer provided Health Insurance	❑ COBRA	❑ Private Pay Health Insurance	❑ State Adult Health Insurance

General Information – Child 3

First Name: _____ Middle Name: _____

Last Name: _____ Suffix: _____

Health Insurance			
❑ No Health Insurance	❑ Client Doesn't Know	❑ Client Refused	❑ Other_____
❑ MEDICAID	❑ MEDICARE	❑ State Children's Health Insurance	❑ Veteran's - VA Medical Services
❑ Employer provided Health Insurance	❑ COBRA	❑ Private Pay Health Insurance	❑ State Adult Health Insurance