

# HMIS Data Collection Template for ANNUAL ASSESSMENT – CoC Program

*\*This form may be used for interim updates and client follow ups as well\**

FOR TEXT FIELDS, USE BLOCK LETTERS. OTHERWISE, MARK APPROPRIATE BOXES WITH AN “X”  
 Fill out separate form for each household member and clip together.

Assessment Date (e.g., 08/24/2016) [All clients]

HMIS ID#: \_\_\_\_\_

|  |  |   |  |  |   |  |  |  |  |
|--|--|---|--|--|---|--|--|--|--|
|  |  | / |  |  | / |  |  |  |  |
|--|--|---|--|--|---|--|--|--|--|

Month                      Day                      Year

CLIENT (name or other identifier)

Client Location: FL-506

Income from any source?     Yes     No     Client doesn't know     Client refused

Total monthly income (indicate “0” if no income): \$ \_\_\_\_\_

| Source of Income                               | Receiving Income Source?                           |    |
|--|--|----|
|  | Yes (if yes, indicate exact or approximate amount) | No |
| Alimony or other spousal support               | \$   |    |
| Child support                                  | \$   |    |
| Earned income (i.e. employment income)         | \$   |    |
| General Assistance (GA)                        | \$   |    |
| Other source (if yes, specify):                | \$   |    |
| Pension or retirement income from former job   | \$   |    |
| Private disability insurance                   | \$   |    |
| Retirement income from Social Security         | \$   |    |
| Supplemental Security Income (SSI)             | \$   |    |
| Social Security Disability Income (SSDI)       | \$   |    |
| Temporary Assistance for Needy Families (TANF) | \$   |    |
| Unemployment Insurance                         | \$   |    |
| VA Non-Service-Connected Disability Pension    | \$   |    |
| VA Service-Connected Disability Compensation   | \$   |    |
| Worker's Compensation                          | \$   |    |

Non-cash benefit from any source?  Yes  No  Client doesn't know  Client refused

| Non-cash Benefit Source  | Currently Receiving Benefit? |    |
|--|------------------------------|----|
|  | Yes                          | No |
| Special Supplemental Nutrition Assistance Program (SNAP)                                 | Amount: \$                   |    |
| Special Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC) |                              |    |
| TANF Child Care Services (or use local name):  |                              |    |
| TANF transportation services (or use local name):  |                              |    |
| Other TANF-Funded services (or use local name)   |                              |    |
| Section 8, Public Housing, or other rental assistance                                    |                              |    |
| Temporary rental assistance. If yes, specify source:                                     |                              |    |
| Other Source (specify):  |                              |    |

**Covered by health Insurance?**

Yes  No

Client doesn't know

Client refused

*[Answer 'yes' or 'no' for each health insurance source with an 'x'. Answer 'no' for sources that are not currently active]*

| Health Insurance Type                          | Covered? |    |
|--|----------|----|
|  | YES      | NO |
| Medicaid                                       |          |    |
| Medicare                                       |          |    |
| State Children's Health Insurance Program      |          |    |
| Veteran's Administration (VA) Medical Services |          |    |
| Employer-provided Health Insurance             |          |    |
| Health insurance obtained through COBRA        |          |    |
| Private Pay Health Insurance                   |          |    |
| State Health Insurance for Adults              |          |    |
| Indian Health Services Program                 |          |    |
| Other (please indicate):                       |          |    |

**Domestic Violence Victim/Survivor?**  
 Yes  No  Client Doesn't Know  Client Refused

**If yes for Domestic Violence Victim/Survivor, when experience occurred:**

Within past 3 months  3-6 months ago  6-12 months  > a year  Client Doesn't Know  Client Refused

**If yes for Domestic violence Victim/Survivor, are you currently fleeing?**

Yes  No  Client Doesn't Know  Client Refused

Date of Engagement (for Street Outreach): \_\_\_\_/\_\_\_\_/\_\_\_\_

Housing Move-in Date: \_\_\_\_/\_\_\_\_/\_\_\_\_