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| Logo  Description automatically generated | **FY24 CARES COLLABORATIVE HMIS RAPID REHOUSING ANNUAL ASSESSMENT** |

*Instructions: Fill out one form per client/household member. Starred (\*) questions require a response.*

**UNIVERSAL DATA ELEMENTS**

Questions below are required for: All Clients & Household Members

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| \*Annual Assessment Date | \*First Name | | | | | | \*Last Name & Suffix | |
| \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |  | | | | | |  | |
| \*Has this client moved into permanent housing? | | | | | \*If YES, What date did they move in? | | | |
| qNo qYes | | | | | **\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_** | | | |
| \*Do you have any type of income? – **If Yes,** indicate and provide the monthly amount for all sources that apply below | | | | | | | | |
| qNo qYes  qEarned Income (i.e., employment pay)  qSupplemental Security Income (SSI)  qVA Service-Connected Disability Compensation  qPrivate Disability Insurance  qTemporary Assistance for Needy Families (TANF)  qRetirement Income from Social Security  qChild Support | | | | $\_\_\_\_\_\_  $\_\_\_\_\_\_  $\_\_\_\_\_\_  $\_\_\_\_\_\_  $\_\_\_\_\_\_  $\_\_\_\_\_\_  $\_\_\_\_\_\_ | qUnemployment Insurance  qSocial Security Disability Insurance (SSDI)  qVA Non-Service-Connected Disability Pension  qWorker’s Compensation  qGeneral Assistance  qPension or Retirement Income from a Former Job  qAlimony or Other Spousal Support | | | $\_\_\_\_\_\_  $\_\_\_\_\_\_  $\_\_\_\_\_\_  $\_\_\_\_\_\_  $\_\_\_\_\_\_  $\_\_\_\_\_\_  $\_\_\_\_\_\_ |
| q*Doesn’t Know* q*Prefers Not to Answer*  q*Not Collected* | | | | | | | | |
| \*Are you receiving any type of non-cash benefits? – **If Yes**, indicate all sources that apply below | | | | | | | | |
| qNo qYes  qSNAP (Food Benefits)  qTANF Child Care Services | | | qSpecial supplemental Nutrition Program for Women, Infants and Children (WIC)  qTANF Transportation Services  qOther TANF-Funded Services | | | | | |
| q*Doesn’t Know* q*Prefers Not to Answer*  q*Not Collected* | | | | | | | | |
| \*Are you covered by health insurance? – **If Yes**, indicate all sources below | | | | | | | | |
| qNo qYes  qMEDICAID  qVA Medical Services  qPrivate Pay Health Insurance | | qMEDICARE  qEmployer-Provided Health Insurance  qState Health Insurance for Adults | | | | qState Children’s Health Insurance Program  qHealth Insurance Through COBRA  qIndian Health Services Program | | |
| q*Doesn’t Know* q*Prefers Not to Answer*  q*Not Collected* | | | | | | | | |
| \*Are you a survivor of Domestic Violence? – If Yes, please answer the additional questions **Head of Household & Adults** | | | | | | | | |
| qNo qYes gWhen did the experience occur qWithin the past 3 months q4-6 months ago q7-12 months ago qOver 1 year ago  Is this person currently fleeing qNo qYes q*Doesn’t Know* q*Prefers Not to Answer*  q*Not Collected* | | | | | | | | |

**(End)**