DATA FOR ALL ADULTS

A separate form should be included for each household member.

FORM TYPE:

Update ☐ **Annual Review** ☐

CLIENT (name or other identifier)

UPDATE / ANNUAL REVIEW DATE (e.g., 08/24/2017)

		/			/				
Month			Day			Year			

INCOME AND SOURCES

Does the client have any income from any source?

☐ No
☐ Yes
☐ Client doesn't know
☐ Client refused

[IF YES] Answer Yes or No for each income source.

Receiving Income?		Source of Income	Monthly amount from source (round to nearest dollar)
☐No	☐Yes	Earned income (employment income)	$. 0 0
☐No	☐Yes	Unemployment Insurance	$. 0 0
☐No	☐Yes	Supplemental Security Income (SSI)	$. 0 0
☐No	☐Yes	Social Security Disability Insurance (SSDI)	$. 0 0
☐No	☐Yes	VA Service-Connected Disability Compensation	$. 0 0
☐No	☐Yes	VA Non-Service-Connected Disability Pension	$. 0 0
☐No	☐Yes	Private disability insurance	$. 0 0
☐No	☐Yes	Worker's Compensation	$. 0 0
☐No	☐Yes	Temporary Assistance for Needy Families (TANF)	$. 0 0
☐No	☐Yes	General Assistance (GA)	$. 0 0
☐No	☐Yes	Retirement Income from Social Security	$. 0 0
☐No	☐Yes	Pension or retirement income from a former job	$. 0 0
☐No	☐Yes	Child support	$. 0 0
☐No	☐Yes	Alimony or other spousal support	$. 0 0
☐No	☐Yes	Other source:_____	$. 0 0
		Total monthly income from all sources	$. **0 0**

NON-CASH BENEFITS

Does the client have any non-cash benefits from any source?

☐ No	☐ Client doesn't know
☐ Yes	☐ Client refused

[IF YES] Answer 'Yes' or 'No' for each non-cash benefit source.

	Receiving Benefits?	
Supplemental Nutrition Assistance Program (SNAP)	☐No	☐Yes
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	☐No	☐Yes
TANF Child Care services *(or use local name)*	☐No	☐Yes
TANF transportation services *(or use local name)*	☐No	☐Yes
Other TANF-Funded Services *(or use local name)*	☐No	☐Yes
Other source, specify source:_____	☐No	☐Yes

EMPLOYED?:

☐ Client refused	☐ Client doesn't know
☐ Yes **# of Hours/week:**_____	☐ No

If Yes:

- ☐ Full-time
- ☐ Part-time
- ☐ Seasonal/Sporadic

If No:

- ☐ Looking for work
- ☐ Unable to work
- ☐ Not Looking for work

HEALTH INSURANCE

Is the client currently covered by health insurance?

☐ No	☐ Client doesn't know
☐ Yes	☐ Client refused

[IF YES] Answer 'Yes' or 'No' for each health insurance source.

No	Yes	Source
☐	☐	Medicaid
☐	☐	Medicare
☐	☐	State Children's Health Insurance Program (or use local name)
☐	☐	Veteran's Administration (VA) Medical Services
☐	☐	Employer-Provided Health Insurance
☐	☐	Health insurance obtained through COBRA
☐	☐	Private Pay Health Insurance
☐	☐	State Health Insurance for Adults (or use local name)
☐	☐	Indian Health Services Program
☐	☐	Other If Yes, specify source: _____

MENTAL HEALTH LINKAGE

If linked with a mental health agency, which one?:

☐ Not currently linked but NEEDS linkage

☐ Not currently linked, does NOT need linkage

----------Begin HIPAA Assessment----------

DISABLING CONDITION

☐ No ☐ Client doesn't know

☐ Yes ☐ Client refused

[IF YES] Answer 'Yes' or 'No' for each Disability Type.

No	Yes	Disability Type	[IF YES], expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?
☐	☐	Physical Disability	☐No ☐Yes ☐Doesn't Know ☐Refused
☐	☐	Developmental Disability	☐No ☐Yes ☐Doesn't Know ☐Refused
☐	☐	Chronic Health Condition	☐No ☐Yes ☐Doesn't Know ☐Refused
☐	☐	HIV/AIDS	☐No ☐Yes ☐Doesn't Know ☐Refused
☐	☐	Mental Health Problem	☐No ☐Yes ☐Doesn't Know ☐Refused
☐	☐	Substance Abuse: ☐Drug ☐Alcohol ☐Both Drug & Alcohol	☐No ☐Yes ☐Doesn't Know ☐Refused
☐	☐	Other If Yes, specify source: _____	☐No ☐Yes ☐Doesn't Know ☐Refused

Pregnant?:

☐ No ☐ Client doesn't know

☐ Yes ☐ Client refused

Projected Due Date:

		/			/				
Month			Day			Year			

DOMESTIC VIOLENCE

Is client a domestic violence victim/survivor?

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused

[IF YES] When did the experience occur?

☐	Within the past three months	☐	One year ago or more
☐	Three to six months ago (excluding six months exactly)	☐	Client doesn't know
☐	Six months to one year ago (excluding one year exactly)	☐	Client refused

[IF YES] Is the client currently fleeing?

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused

----------End HIPAA Assessment----------

Last Grade Completed:

Received Vocational Training?

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused

Client Signature:_____ **Date:**_____

Staff Signature:_____ **Date:**_____