Client ID # _____

HMIS Data Collection Template – Interim/Annual Assessment (HUD)

This questionnaire is to be administered by case workers. Please fill out for EVERY household member at **the one-year (365 days) program entry-date anniversary** or **anytime** income, non-cash benefit (SNAP, WIC, EBT…etc.) and/or health insurance information changes for any **adult household member over 18 years of age**. All clients over 18 years old must have signed the consent form for HMIS – if expired, client must consent and sign a new consent form.

PROGRAM NAME:	
CASE MANAGER NAME:	
CLIENT NAME:	
INITIAL PROJECT START DATE:	
DATE OF DATA COLLECTION:	
ANNUAL ASSESSMENT?	☐YES ☐NO

Before you Begin- Please verify the following Universal Data Elements: Name, Social Security Number, Date of Birth, Race, Ethnicity, Gender, Veteran Status, Residence Prior to Project Entry, Length of Time on Street or in Emergency Shelter, and Relationship to Head of Household. Please take a thorough look at the existing record in HMIS to identify any missing or potentially flawed data and make note of missing information before you interview the client.

Income and Sources (As of Interim Update/Annual Assessment)

Income from ANY source? *If Yes for "Income from ANY source," indicate all sources and dollar amounts for the source(s) that apply.*	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused

Monthly Income (Cash) Source:		**Monthly Amount:**
Earned Income (i.e., employment income)	☐ No ☐ Yes	$
Unemployment Insurance	☐ No ☐ Yes	$
Supplemental Security Income (SSI)	☐ No ☐ Yes	$
Social Security Disability Income (SSDI)	☐ No ☐ Yes	$
VA Service-Connected Disability Compensation	☐ No ☐ Yes	$
VA Non-Service-Connected Disability Compensation	☐ No ☐ Yes	$
Private Disability Insurance	☐ No ☐ Yes	$
Workers Compensation	☐ No ☐ Yes	$
Temporary Assistance for Needy Families (TANF)	☐ No ☐ Yes	$
General Assistance (GA)	☐ No ☐ Yes	$
Retirement Income from Social Security	☐ No ☐ Yes	$
Pension/Retirement Income from Former Job	☐ No ☐ Yes	$
Child Support	☐ No ☐ Yes	$
Alimony or other Spousal Support	☐ No ☐ Yes	$
Other Source – SPECIFY HERE: _____	☐ No ☐ Yes	$
MONTHLY INCOME TOTAL:		**$**

Assessment Continued on Page 2 of 2.

Client ID # _____

HMIS Data Collection Template – Interim/Annual Assessment (HUD)

This questionnaire is to be administered by case workers. Please fill out for EVERY household member at **the one-year (365 days) program entry-date anniversary** or **anytime** income, non-cash benefit (SNAP, WIC, EBT…etc.) and/or health insurance information changes for any **adult household member over 18 years of age**. All clients over 18 years old must have signed the consent form for HMIS – if expired, client must consent and sign a new consent form.

Non-Cash Benefits (As of Interim Update/Annual Assessment)		
Non-Cash Benefit from ANY source? *If Yes for "Non-Cash Benefit from ANY source," indicate all sources and dollar amounts for the source(s) that apply.*	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused	
Non-Cash Benefit Source:		**Monthly Amount:**
Supplemental Nutrition Assistance Program (SNAP)	☐ No ☐ Yes	$
Special Supplemental Nutrition Program (WIC)	☐ No ☐ Yes	$
TANF Child Care Services	☐ No ☐ Yes	$
TANF Transportation Services	☐ No ☐ Yes	$
Other TANF-Funded Services	☐ No ☐Yes	$
Other Source – SPECIFY HERE: _____	☐ No ☐Yes	$
MONTHLY NON-CASH BENEFITS TOTAL:		$

_____

Health Insurance (As of Interim Update/Annual Assessment)	
Covered by Health Insurance? *If Yes for "Income from ANY source," indicate all sources and dollar amounts for the source(s) that apply.*	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused

Health Insurance Source	**Covered?**
Medicaid (Low-Income Families or Individuals)	☐ No ☐ Yes
Medicare (65+ or Some Younger Clients With Disabilities)	☐ No ☐ Yes
State Children's Health Insurance Program; STATE: _____	☐ No ☐ Yes
Veterans Administration (VA) Medical Services	☐ No ☐ Yes
Employer-Provided Health Insurance	☐ No ☐ Yes
Health Insurance Obtained through COBRA	☐ No ☐ Yes
Private Pay Health Insurance; SPECIFY: _____	☐ No ☐ Yes
State Health Insurance for Adults; STATE: _____	☐ No ☐ Yes
Indian Health Services Program	☐ No ☐ Yes
Other; SPECIFY:_____	☐ No ☐ Yes

_____

For Office Use Only:

☐ PLEASE CHECK WHEN THIS INTERIM UPDATE/ANNUAL ASSESSMENT HAS BEEN PUT INTO HMIS.