

Interim Assessment –PSH

This form should be used by Permanent Supportive Housing Projects for all clients. (children pages 1-2; all adults pages 1-3; heads of household pages 1-4)

ANSWER FOR ALL HOUSEHOLD MEMBERS

Date Of Interim Assessment								
		/			/			
Month		Day		Year				

Type Of Interim	
<input type="checkbox"/> Update	<input type="checkbox"/> Annual Assessment

Client Name

HMIS Client ID - For HMIS Users only								

Disability Status - Do you have a disabling condition?				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> Data not collected

Answer 'Yes' or 'No' for each disability type (in white).

Only select YES if the disability type is expected to be long-continued and indefinite and substantially impairs your ability to live independently.

For Office HMIS Users Only: If the client identifies Yes for any disability type, mark *Disability Determination* and *Long-Continued or Indefinite Duration* questions as Yes. The disability type's Start Date will be the Project Start Date.

Disability Type	Yes	No
Physical	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Health Condition	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Developmental	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Use Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Substance Use Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Disorder	<input type="checkbox"/>	<input type="checkbox"/>

Health Insurance – Are you currently covered by health insurance?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> Data not collected
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Answer 'Yes' or 'No' for each health insurance source.

Answer 'Yes' for any source that is currently received.

Answer 'No' for sources that have been terminated, even if they were received in the past.

For Office HMIS Users Only: If the client identifies Yes for any insurance type, the health insurance type's Start Date will be the Project Start Date.

Health Insurance Type	Yes	No
Medicaid	<input type="checkbox"/>	<input type="checkbox"/>
Medicare	<input type="checkbox"/>	<input type="checkbox"/>
State Children's Health Insurance Program (or North Carolina Health Choice)	<input type="checkbox"/>	<input type="checkbox"/>
Veteran's Health Administration (VHA)	<input type="checkbox"/>	<input type="checkbox"/>
Employer-Provided Health Insurance	<input type="checkbox"/>	<input type="checkbox"/>
Health insurance obtained through COBRA	<input type="checkbox"/>	<input type="checkbox"/>
Private Pay Health Insurance	<input type="checkbox"/>	<input type="checkbox"/>
State Health Insurance for Adults	<input type="checkbox"/>	<input type="checkbox"/>
Indian Health Services Program	<input type="checkbox"/>	<input type="checkbox"/>
Other If Yes, specify source:	<input type="checkbox"/>	<input type="checkbox"/>

NC County Of Service In which NC county are you receiving this project's services?	
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ANSWER THESE QUESTIONS FOR HEAD OF HOUSEHOLD AND OTHER ADULTS

Housing Move-In Date			/			/			
	Month			Day			Year		

Income and Sources - Do you currently have any income from any source?				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> Data not collected

To complete the table below, you must answer 'Yes' or 'No' for each monthly income source.
 Answer 'Yes' only if the income source is recurrent and received as of today (i.e. not terminated). Children's income (except earned income) can be included under the Head of Household's information.
 Answer 'No' for sources that have been terminated, even if they were received in the past.
If the response for any source is 'Yes', complete the amount in the shaded section below.
 For Office HMIS Users Only: If the client identifies Yes for any income source, the source's Start Date will be the Project Start Date.

Source of Income	Yes	No	If yes, monthly amount from source (round to nearest dollar)
Earned income (i.e., employment income)	<input type="checkbox"/>	<input type="checkbox"/>	\$
Unemployment Insurance	<input type="checkbox"/>	<input type="checkbox"/>	\$
Supplemental Security Income (SSI)	<input type="checkbox"/>	<input type="checkbox"/>	\$
Social Security Disability Income (SSDI)	<input type="checkbox"/>	<input type="checkbox"/>	\$
VA Service-Connected Disability Compensation	<input type="checkbox"/>	<input type="checkbox"/>	\$
VA Non-Service-Connected Disability Pension	<input type="checkbox"/>	<input type="checkbox"/>	\$
Private disability insurance	<input type="checkbox"/>	<input type="checkbox"/>	\$
Worker's Compensation	<input type="checkbox"/>	<input type="checkbox"/>	\$
Temporary Assistance for Needy Families (TANF)	<input type="checkbox"/>	<input type="checkbox"/>	\$
General Assistance (GA)	<input type="checkbox"/>	<input type="checkbox"/>	\$
Retirement Income from Social Security	<input type="checkbox"/>	<input type="checkbox"/>	\$
Pension or retirement income from a former job	<input type="checkbox"/>	<input type="checkbox"/>	\$
Child support	<input type="checkbox"/>	<input type="checkbox"/>	\$
Alimony or other spousal support	<input type="checkbox"/>	<input type="checkbox"/>	\$
Other source:	<input type="checkbox"/>	<input type="checkbox"/>	\$
Total monthly income from all sources			\$

Non-Cash Benefits - Do you have any non-cash benefits from any source?				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> Data not collected

To complete the table below, you must answer 'Yes' or 'No' for each non-cash benefit.
 Answer 'Yes' only if the non-cash benefit is recurrent and received as of today (i.e. not terminated).
 Answer 'No' for non-cash benefit that have been terminated, even if they were received in the past.
If the response for any non-cash benefit is 'Yes', complete the shaded section.
 For Office HMIS Users Only: If the client identifies Yes for any non-cash benefit, the benefit's Start Date will be the Project Start Date.

Source of Non-Cash Benefit	Yes	No	If yes, monthly amount from source (round to nearest dollar)
Supplemental Nutrition Assistance Program (SNAP)	<input type="checkbox"/>	<input type="checkbox"/>	\$

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	<input type="checkbox"/>	<input type="checkbox"/>	\$
TANF Child Care services (or use local name)	<input type="checkbox"/>	<input type="checkbox"/>	\$
TANF transportation services (or use local name)	<input type="checkbox"/>	<input type="checkbox"/>	\$
Other TANF-Funded Services (or use local name)	<input type="checkbox"/>	<input type="checkbox"/>	\$
Other source:	<input type="checkbox"/>	<input type="checkbox"/>	\$

Domestic Violence - Are you a survivor of domestic violence?				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> Data not collected



If Yes, when did the experience occur?	
<input type="checkbox"/> Within the past three months	<input type="checkbox"/> Don't know
<input type="checkbox"/> Three to six months ago (excluding six months exactly)	<input type="checkbox"/> Prefer not to answer
<input type="checkbox"/> Six months to one year ago (excluding one year exactly)	<input type="checkbox"/> Data not collected
<input type="checkbox"/> One year ago or more	



If Yes, are you currently fleeing?				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="checkbox"/> Prefer not to answer	<input type="checkbox"/> Data not collected

ANSWER THESE QUESTIONS FOR HEAD OF HOUSEHOLDS ONLY

Coordinated Entry Event – For Office HMIS Users Only	
Start Date / Date Of Event	
Event	
Access Events	<input type="checkbox"/> Referral to Prevention Assistance project
	<input type="checkbox"/> Problem Solving/Diversion/Rapid Resolution intervention or service → Go to A
	<input type="checkbox"/> Referral to scheduled Coordinated Entry Crisis Needs Assessment
	<input type="checkbox"/> Referral to scheduled Coordinated Entry Housing Needs Assessment → Go to B
Referral Events	<input type="checkbox"/> Referral to post-placement/follow-up case management
	<input type="checkbox"/> Referral to Street Outreach project or services
	<input type="checkbox"/> Referral to Housing Navigation project or services
	<input type="checkbox"/> Referral to Non-continuum services: Ineligible for continuum services
	<input type="checkbox"/> Referral to Non-continuum services: No availability in continuum services
	<input type="checkbox"/> Referral to Emergency Shelter bed opening
	<input type="checkbox"/> Referral to Transitional Housing bed/unit opening
	<input type="checkbox"/> Referral to Joint TH-RRH project/unit/resource opening
	<input type="checkbox"/> Referral to RRH project resource opening
	<input type="checkbox"/> Referral to PSH project resource opening
	<input type="checkbox"/> Referral to Other PH project/unit/resource opening
<input type="checkbox"/> Referral to emergency assistance/flex fund/furniture assistance	
<input type="checkbox"/> Referral to a Housing Stability Voucher	
If 'Event' answer was 'Problem Solving/Diversion/Rapid Re-Housing intervention or service result', please answer A:	
A. Problem Solving/Diversion/Rapid Resolution intervention or service result – Client housed/re-housed in a safe alternative?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If 'Event' answer was 'Referral to post-placement/follow-up case management result', please answer B:									
B. Referral to post-placement/follow-up case management result – Enrolled in Aftercare project?	<input type="checkbox"/> Yes			<input type="checkbox"/> No					
If 'Event' answer was Referral to an ES, TH, Joint TH-RRH, RRH, PSH, or Other PH opening, please answer C-E:									
C. Location of Crisis Housing or Permanent Housing Referral (Project name or Project ID)									
D. Referral Result (if applicable)	<input type="checkbox"/> Client accepted		<input type="checkbox"/> Client rejected		<input type="checkbox"/> Provider rejected				
E. Date of Result (if applicable)			/			/			

MOVING ON ASSISTANCE PROVIDED									
DATE OF MOVING ON ASSISTANCE			/			/			
EVENT									
<input type="checkbox"/> Subsidized housing application assistance									
<input type="checkbox"/> Financial assistance for Moving On (e.g., security deposit, moving expenses)									
<input type="checkbox"/> Non-financial assistance for Moving On (e.g., housing navigation, transition support)									
<input type="checkbox"/> Housing referral/placement									
<input type="checkbox"/> Other, please specify:									