COHMIS

HOPWA Assessment Form

CLIENT NAME			
Last:			
First:			
Middle:		Suffix	

PROJECT NAME	
ASSESSMENT DATE (MM/DD/YYYY)	
ASSESSMENT TYPE	☐ Annual Assessment ☐ Status Update

Permanent Housing Projects Only (TBRA & Facility Based)

If Client is in a Permanent Housing Situation at time of Assessment:	
HOUSING MOVE-IN DATE *(enter on Enrollment Screen for Head of Household)*	MONTH DAY YEAR
ZIP CODE:	

DISABLING CONDITION

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

PHYSICAL DISABILITY

☐ No
☐ Yes*

☐ Client doesn't know
☐ Client refused
☐ Data not collected

***If YES for Physical Disability**
Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

DEVELOPMENTAL DISABILITY

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

CHRONIC HEALTH CONDITION

☐ No
☐ Yes*

☐ Client doesn't know
☐ Client refused
☐ Data not collected

***If YES for Chronic Health Condition**
Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

HIV/AIDS

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

MENTAL HEALTH PROBLEM

☐ No
☐ Yes*

☐ Client doesn't know
☐ Client refused
☐ Data not collected

***If YES for Mental Health Problem**
Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

SUBSTANCE ABUSE PROBLEM

☐ No
☐ Alcohol abuse
☐ Drug abuse
☐ Both alcohol and drug abuse

☐ Client doesn't know
☐ Client refused
☐ Data not collected

***If YES for Substance Abuse Problem**
Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

DOMESTIC VIOLENCE VICTIM/SURVIVOR		
	☐ No ☐ Yes*	☐ Client doesn't know ☐ Client refused ☐ Data not collected
***If YES to Domestic Violence Victim/Survivor**		
When did this experience occur?	☐ Within the past three months ☐ Three to six months ago (excluding six months exactly) ☐ From six to twelve months ago (excluding one year exactly) ☐ More than a year ago	☐ Client doesn't know ☐ Client refused ☐ Data not collected
Are you currently fleeing?	☐ No ☐ Yes	☐ Client doesn't know ☐ Client refused ☐ Data not collected

CASH INCOME FOR INDIVIDUAL		
Income from Any Source?	☐ No ☐ Yes*	☐ Client doesn't know ☐ Client refused ☐ Data not collected

***If YES to Income from Any Source – Indicate all sources that apply**

Income Source (Check all that apply)	Monthly Amount
☐ Earned Income	
☐ Unemployment Insurance	
☐ Supplemental Security Income (SSI)	
☐ Social Security Disability Insurance (SSDI)	
☐ VA Service-Connected Disability Compensation	
☐ VA Non-Service Connected Disability Pension	
☐ Private Disability Insurance	
☐ Worker's Compensation	
☐ Temporary Assistance for Needy Families (TANF)	
☐ General Assistance (GA)	
☐ Retirement Income from Social Security	
☐ Pension or Retirement Income from a Former Job	
☐ Child Support	
☐ Alimony and Other Spousal Support	
☐ Other Cash Income (Specify: _____)	
Total Monthly Amount	

NON-CASH BENEFITS		
Receiving Non-Cash Benefits?	☐ No ☐ Yes*	☐ Client doesn't know ☐ Client refused ☐ Data not collected

***If YES to Receiving Non-Cash Benefits – Indicate all sources that apply**

☐ Supplemental Nutrition Assistance Program (SNAP)
☐ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
☐ TANF Childcare Services
☐ TANF Transportation Services
☐ Other TANF-Funded Services
☐ Other Non-Cash Benefit (Specify source:_____)

HEALTH INSURANCE		
Covered by Health Insurance?	☐ No ☐ Yes*	☐ Client doesn't know ☐ Client refused ☐ Data not collected

***If YES to Covered by Health Insurance – Indicate all sources that apply AND Indicate Reason Not Covered by any Insurance Sources client does not have**

Health Insurance Source	Reason Not Covered by Specific Insurance Source
☐ Medicaid	☐ Applied; decision pending ☐ Applied; client not eligible ☐ Client did not apply ☐ Insurance type N/A for this client ☐ Client doesn't know ☐ Client refused ☐ Data not collected
☐ Medicare	☐ Applied; decision pending ☐ Applied; client not eligible ☐ Client did not apply ☐ Insurance type N/A for this client ☐ Client doesn't know ☐ Client refused ☐ Data not collected
☐ State Children's Health Insurance Program	☐ Applied; decision pending ☐ Applied; client not eligible ☐ Client did not apply ☐ Insurance type N/A for this client ☐ Client doesn't know ☐ Client refused ☐ Data not collected
☐ Veteran's Administration (VA) Medical Services	☐ Applied; decision pending ☐ Applied; client not eligible ☐ Client did not apply ☐ Insurance type N/A for this client ☐ Client doesn't know ☐ Client refused ☐ Data not collected
☐ Employer-Provided Health Insurance	☐ Applied; decision pending ☐ Applied; client not eligible ☐ Client did not apply ☐ Insurance type N/A for this client ☐ Client doesn't know ☐ Client refused ☐ Data not collected

Health Insurance Sources continued on next page →

Health Insurance Source (cont'd)	Reason Not Covered by Specific Insurance Source
☐ Health Insurance Obtained Through COBRA	☐ Applied; decision pending ☐ Applied; client not eligible ☐ Client did not apply ☐ Insurance type N/A for this client ☐ Client doesn't know ☐ Client refused ☐ Data not collected
☐ Private Pay Health Insurance	☐ Applied; decision pending ☐ Applied; client not eligible ☐ Client did not apply ☐ Insurance type N/A for this client ☐ Client doesn't know ☐ Client refused ☐ Data not collected
☐ State Health Insurance for Adults	☐ Applied; decision pending ☐ Applied; client not eligible ☐ Client did not apply ☐ Insurance type N/A for this client ☐ Client doesn't know ☐ Client refused ☐ Data not collected
☐ Indian Health Services Program	☐ Applied; decision pending ☐ Applied; client not eligible ☐ Client did not apply ☐ Insurance type N/A for this client ☐ Client doesn't know ☐ Client refused ☐ Data not collected
☐ Other Health Insurance	(Specify Source: _____)

MEDICAL ASSISTANCE		
Receiving Public HIV/AIDS Medical Assistance?	☐ No* ☐ Yes	☐ Client doesn't know ☐ Client refused ☐ Data not collected
***If NO for Receiving Public HIV/AIDS Medical Assistance**		
☐ Applied; decision pending ☐ Applied; client not eligible ☐ Client did not apply ☐ Insurance type N/A for this client		☐ Client doesn't know ☐ Client refused ☐ Data not collected
Receiving AIDS Drug Assistance Program (ADAP)?	☐ No* ☐ Yes	☐ Client doesn't know ☐ Client refused ☐ Data not collected
***If NO for Receiving AIDS Drug Assistance Program**		
☐ Applied; decision pending ☐ Applied; client not eligible ☐ Client did not apply ☐ Insurance type N/A for this client		☐ Client doesn't know ☐ Client refused ☐ Data not collected

T-CELL (CD4) AND VIRAL LOAD		
T-cell (CD4) Count Available?	☐ No ☐ Yes*	☐ Client doesn't know ☐ Client refused ☐ Data not collected
***If YES to T-Cell (CD4) Count Available, T-Cell Count (# between 0 – 1500) =**		
If a # is entered in the T-Cell (CD4) count, then how was information obtained?		☐ Medical report ☐ Client report ☐ Other
Viral load information available?	☐ Not available ☐ Available* ☐ Undetectable	☐ Client doesn't know ☐ Client refused ☐ Data not collected
***If Viral Load Information is AVAILABLE, then Count (# between 0 – 999999) =**		
If a # is entered in the Viral Load count, then how was information obtained?		☐ Medical report ☐ Client report ☐ Other

CONTACT INFORMATION (Optional – entered on the **Contacts** tab)	
Phone number	
Email	

ADDRESS (Optional – entered on the **Locations** tab)			
Street			
City			
State		Zip Code	

Signature of applicant stating all information is true and correct

Date