



# COHMIS

## VA Assessment Form

HUD-VASH, Contract Residential Services (CRS), Grant Per Diem (GPD)

CLIENT NAME			
Last:			
First:			
Middle:		Suffix	

PROJECT NAME								
ASSESSMENT DATE (MM/DD/YYYY)								
ASSESSMENT TYPE	<input type="checkbox"/> Annual Assessment				<input type="checkbox"/> Status Update			

### HUD-VASH & VA GPD Transition in Place Projects only

If Client is in a Permanent Housing Situation at time of Assessment:																			
<b>HOUSING MOVE-IN DATE</b> <i>(enter on Enrollment Screen for Head of Household)</i>	<table border="1"> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="3">MONTH</td> <td colspan="3">DAY</td> <td colspan="3">YEAR</td> </tr> </table>										MONTH			DAY			YEAR		
MONTH			DAY			YEAR													
ZIP CODE:																			

DISABLING CONDITION	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
PHYSICAL DISABILITY	
<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>*If YES for Physical Disability</b> <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
DEVELOPMENTAL DISABILITY	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
CHRONIC HEALTH CONDITION	
<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>*If YES for Chronic Health Condition</b> <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
HIV/AIDS	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
MENTAL HEALTH PROBLEM	
<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>*If YES for Mental Health Problem</b> <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
SUBSTANCE ABUSE PROBLEM	
<input type="checkbox"/> No <input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Drug abuse <input type="checkbox"/> Both alcohol and drug abuse	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>*If YES for Substance Abuse Problem</b> <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

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

CASH INCOME FOR INDIVIDUAL	
Income from Any Source?	<input type="checkbox"/> No <input type="checkbox"/> Yes* <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
*If YES to Income from Any Source – Indicate all sources that apply	
Income Source (Check all that apply)	Monthly Amount
<input type="checkbox"/> Earned Income	
<input type="checkbox"/> Unemployment Insurance	
<input type="checkbox"/> Supplemental Security Income (SSI)	
<input type="checkbox"/> Social Security Disability Insurance (SSDI)	
<input type="checkbox"/> VA Service-Connected Disability Compensation	
<input type="checkbox"/> VA Non-Service Connected Disability Pension	
<input type="checkbox"/> Private Disability Insurance	
<input type="checkbox"/> Worker's Compensation	
<input type="checkbox"/> Temporary Assistance for Needy Families (TANF)	
<input type="checkbox"/> General Assistance (GA)	
<input type="checkbox"/> Retirement Income from Social Security	
<input type="checkbox"/> Pension or Retirement Income from a Former Job	
<input type="checkbox"/> Child Support	
<input type="checkbox"/> Alimony and Other Spousal Support	
<input type="checkbox"/> Other Cash Income (Specify: _____)	
<b>Total Monthly Amount</b>	

NON-CASH BENEFITS	
<b>Receiving Non-Cash Benefits?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes*
	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>*If YES to Receiving Non-Cash Benefits – Indicate all sources that apply</b>	
<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) <input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) <input type="checkbox"/> TANF Childcare Services	<input type="checkbox"/> TANF Transportation Services <input type="checkbox"/> Other TANF-Funded Services <input type="checkbox"/> Other Non-Cash Benefit (Specify source: _____)

HEALTH INSURANCE	
<b>Covered by Health Insurance?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes*
	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>*If YES to Covered by Health Insurance – Indicate all sources that apply</b>	
<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Veteran's Administration (VA) Medical Services <input type="checkbox"/> Employer-Provided Health Insurance	<input type="checkbox"/> Health Insurance Obtained Through COBRA <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Other Health Insurance (Specify source: _____)

CONNECTION WITH SOAR	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

CONTACT INFORMATION (Optional – entered on the <b>Contacts</b> tab)	
Phone number	
Email	

ADDRESS (Optional – entered on the <b>Locations</b> tab)			
Street			
City			
State		Zip Code	

Signature of applicant stating all information is true and correct

Date