|  |
| --- |
| **MCI ID:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **HMIS ID:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Staff Initials/Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Grant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Program Enrollment Date: \_\_\_\_\_\_\_\_\_\_\_\_** |

**HMIS ADULT/CHILD ANNUAL FORM**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Name*** |  | ***Anniversary Date*** |  | ***Assessment/Information Date*** |
|  |  |  |  |  |

**When completing an APR for the HoH, complete one for ALL members**

\*Check all demographic information on the household screen in HMIS to ensure it is all filled in and there is no client refused, client doesn’t know, data not collected\*

|  |  |
| --- | --- |
| **Name** | **Relationship to HOH**  **(child, spouse, other relation member, other non-relation member, HoH)** |
|  | Choose an item. |
|  | Choose an item. |
|  | Choose an item. |
|  | Choose an item. |
|  | Choose an item. |

*Additional Household Members (please fill out a form for each household member mentioned below)*

*Housing Disposition*

|  |  |
| --- | --- |
| **Residential Move-in Date** | **Address** |
| Click or tap to enter a date. |  |
| **Moving On Assistance Date** | **Moving On Assistance provided (select all that apply)** |
| Click or tap to enter a date. | Subsidized housing application assistance  Financial assistance for Moving On (e.g. security deposit, moving expenses)  Non-financial assistance for Moving On (e.g. housing navigation, transition support)  Housing referral/placement  Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

*ESG Rapid Re-Housing and ESG Prevention Funding Source (ESG funded projects only)*

|  |  |  |  |
| --- | --- | --- | --- |
| **Payment Start Date** | **Payment End Date** | | **Funding Source** |
| Click or tap to enter a date. | Click or tap to enter a date. | | Choose an item. |
| **Payment Type (select all that apply)** | | **Amount ($ for each payment type)** | |
| Arrears  Forward Rent  Security Deposit | |  | |

*Domestic Violence*

|  |  |  |
| --- | --- | --- |
| Victim/Survivor | When did this happen? | Currently Fleeing |
| Choose an item. | Choose an item. | Choose an item. |

*Employment (for anyone 18+)*

|  |  |
| --- | --- |
| Yes | No |
| Choose an item. | Choose an item. |

***Income (for anyone 18+)***

YES If Yes, complete table below.  NO If No, skip to the next table.

|  |  |  |  |
| --- | --- | --- | --- |
| Source | If yes, Amount - *monthly* | Source | If yes, Amount - *monthly* |
| Earned Income (Employment) | $ | VA Service-Connected Disability Compensation | $ |
| Unemployment Insurance | $ | VA Non-svc Connected Disability Pension | $ |
| GA | $ | Private Disability Insurance | $ |
| Retirement Income from Social Security | $ | Cash Assistance/TANF | $ |
| Worker’s Compensation | $ | Alimony or Other Spousal Support | $ |
| SSI | $ | Child Support | $ |
| SSDI | $ | UTA | $ |
|  |  | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | $ |

|  |  |  |  |
| --- | --- | --- | --- |
| ***Connection to SOAR*** | Choose an item. | ***Total Monthly Income*** | $ |

*Non-cash Benefits (for anyone 18+)*

**YES** If Yes, complete table below.

**NO** If No, skip to the next table.

|  |
| --- |
| Source (select all that apply) |
| SNAP (Food Stamps)  WIC  TANF Childcare Services  TANF Transportation Services  Other TANF-funded Services  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

*Health Insurance (for all clients)*

**YES** If Yes, complete table below.

**NO** If No, skip to the next table.

|  |
| --- |
| Source (select all that apply) |
| Medicaid  Medicare  State Children’s Health Insurance Program (CHIP)  VA medical services  Employer Provided health insurance  Health insurance obtained through COBRA  Private Pay Health Insurance  State Health Insurance for Adults  Indian Health Services Program |

*Physical and Mental Health*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Disabling Condition | Choose an item. | |  | |  |
| Type | **Expected to be long-term?** | | Type | | Expected to be long-term? |
| Physical | Choose an item. | | HIV/AIDS | | |
| Developmental | | |  | |  |
| Chronic health condition | Choose an item. | |  | |  |
| Mental health disorder | Choose an item. | | Alcohol use disorder | | Choose an item. |
| Drug use disorder | Choose an item. | | Alcohol and drug use disorder | | Choose an item. |
| Well-being | | | | | |
| Client perceives their life has value and worth | Choose an item. | | Client perceives they have support from others who will listen to problems | | Choose an item. |
| Client perceives they have a tendency to bounce back after hard times | Choose an item. | | Client’s frequency of feeling nervous, tense, worried, frustrated, or afraid | | Choose an item. |
| Pregnancy Status (collect for all clients) | | | | | |
| Yes (If Yes, complete table) | | Due Date | | Prenatal Care | |
| No (If No, skip to the next table) | | Click or tap to enter a date. | | Choose an item. | |

*Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Staff Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*