RENTAL ASSISTANCE: PERMANENT SUPPORTIVE HOUSING ANNUAL ASSESSMENT	Date:

Please note the annual assessment must be completed within 30 days of original enrollment date.

Client Name: _____ **Client Email:** _____

Phone Number: _____ **Alternate Number:** _____

Address: _____

Health Insurance: Please select all that apply.

- ☐ Private
- ☐ Private – Employer
- ☐ Private – Individual
- ☐ Medicare
- ☐ Medicaid
- ☐ State Children's Insurance
- ☐ Military Insurance
- ☐ State Funded
- ☐ Combined Children's Health
- ☐ Indian Health Services
- ☐ Other: _____
- ☐ No insurance

Barriers: Please record a status for every barrier.

Barrier:	Barrier Present:	Receiving Services/ Treatment:	Indefinite Condition:	Documentation provided:
Alcohol Abuse	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Chronic Health Condition	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Developmental Disability	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Drug Abuse	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
HIV/AIDS	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Mental Illness	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Physical Disability	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

History of Domestic Violence: ☐ Yes ☐ No **If yes, when:** _____

Currently fleeing? ☐ Yes ☐ No

Source(s) of Income: Please select all that apply.

- ☐ Earned Income _____
- ☐ Unemployment _____
- ☐ SSI _____
- ☐ SSDI _____
- ☐ Veteran's Disability _____
- ☐ Veteran's Pension _____
- ☐ TANF _____
- ☐ Retirement (SSA) _____
- ☐ Child Support _____
- ☐ Other: _____ _____
- ☐ Death Benefit _____
- ☐ No Income _____

Current Gross Monthly Income: $ 0.00

Does the client have a payee? ☐ Yes ☐ No **Payee Name:** _____

Benefits applied for in past year:

- ☐ Retirement (SSA)
- ☐ SSI
- ☐ SSDI
- ☐ Veteran's Pension
- ☐ Veteran's Disability
- ☐ TANF
- ☐ Child Support
- ☐ Employment
- ☐ Food Stamps

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RENTAL ASSISTANCE: PERMANENT SUPPORTIVE HOUSING ANNUAL ASSESSMENT	Date:

Total Rent: _____ **Grant Subsidy:** _____ **Client Copay:** _____

Household Expenses: **Food Stamps:** _____

Rent		Child Support		Tuition	
Food		Credit Cards		Personal	
Electric		Car Insurance		Laundry	
Water		Transportation		Cable	
Telephone		Car Payment		Other:_____	
Medical bills		Gasoline		**TOTAL**	$ 0.00

Please provide <u>two</u> emergency contacts/NOK information:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Case Manager Signature: _____ **Date:** _____

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