KS BOS HMIS

SSVF Assessment Form (RRH & HP)

CLIENT NAME			
Last:			
First:			
Middle:		Suffix	

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

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

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 Compensation	
☐ 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**

- ☐ Medicaid
- ☐ Medicare
- ☐ State Children's Health Insurance Program
- ☐ Veteran's Administration (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
- ☐ Other Health Insurance (Specify source:_____)

CONNECTION WITH SOAR

- ☐ No
- ☐ Yes
- ☐ Client doesn't know
- ☐ Client refused
- ☐ Data not collected

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