MSCCoC_MIS Interim/Update/Annual Assessment

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FOR TEXT FIELDS, USE BLOCK LETTERS. OTHERWISE, MARK APPROPRIATE BOXES WITH AN "X". Complete a separate form for each member of the household.

Date of Data Collection

		/			/				
Month			Day			Year			

Client ID

NAME (first, middle, last name, suffix (e.g., Jr, Sr, III)) [All clients]

First Name:																										
Middle Name:																										
Last Name:																										
Suffix:																										
Alias:																										

Social Security Number: [All clients]

			-			-				

Date of Birth: (e.g., 10/23/1978) [All clients]

		/			/				
Month			Day			Yea			

INCOME & SOURCES *PROOF NEEDED*

What is the Household total monthly income?

$_____

Have you received income from any source? ☐ No ☐ Yes

If yes for "Income from any source:

Indicate all sources and dollar amounts for the source that apply:

No	Yes	Source of Income	Amount	No	Yes	Source of Income	Amount
☐	☐	Earned income (i.e. employment income)	$	☐	☐	Worker's Compensation	$
☐	☐	Supplemental Security Income (SSI)	$	☐	☐	Temporary Assistance for Needy Families (TANF)	$
☐	☐	Social Security Disability Income (SSDI)	$	☐	☐	General Assistance (GA)	$
☐	☐	VA Service Connected Disability Compensation	$	☐	☐	VA Non Service Connected Disability Pension	$
☐	☐	Retirement Income from Social Security	$	☐	☐	Responses Pension or retirement income from a former job	$
☐	☐	Private disability insurance	$	☐	☐	Child support	$
☐	☐	Unemployment Insurance	$	☐	☐	Alimony and other spousal support	$
☐	☐	Other Source (specify	$				

EMPLOYMENT STATUS

Date Information Collected: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year)

Employed?

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

If Yes for "Employed", Type of Employment

☐	Full-time	☐	Part-time	☐	Seasonal /sporadic (including day labor)

If No for "Employed", Why not Employed?

☐	Looking for Work	☐	Unable to Work	☐	Not looking for work

NON-CASH BENEFITS *PROOF NEEDED*

Have you received non-cash benefits from any source? ☐No ☐Yes

If yes for non-cash benefits from any source and dollar amounts for the source that apply:

No	Yes	Source of Benefit	No	Yes	Source of Benefit
☐	☐	Supplemental Nutrition Assistance Program (SNAP) (Previously known as Food Stamps)	☐	☐	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC
☐	☐	SANF Child Care services (or use local name)	☐	☐	Temporary Assistance for Needy Families (TANF)
☐	☐	TANF transportation services (or use local name)	☐	☐	Other TANF unded Services (or use local name)
☐	☐	Section 8, public housing, or other ongoing rental assistance	☐	☐	Temporary rental assistance
☐	☐	Other Source	If yes to "Other" Source, please specify		

DISABILITY INFORMATION *PROOF NEEDED*

Does client have a disability?

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

ALCOHOL ABUSE

☐	No	☐	Yes	Date Information Collected:	☐☐	/	☐☐	/	☐☐☐☐						
					Month		Day		Year						

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

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

Is there Documentation of the disability and severity on file?

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

Currently receiving services/treatment for this disability?

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

CHRONIC HEALTH CONDITION

☐	No	☐	Yes	Date Information Collected:	☐☐	/	☐☐	/	☐☐☐☐						
					Month		Day		Year						

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

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

Is there Documentation of the disability and severity on file?

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

Currently receiving services/treatment for this disability?

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

DEVELOPMENTAL DISABILITY

☐	No	☐	Yes	Date Information Collected:			/			/				
						Month			Day			Year		

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

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

Is there Documentation of the disability and severity on file?

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

Currently receiving services/treatment for this disability?

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

HIV/AIDS

☐	No	☐	Yes	Date Information Collected:			/			/				
						Month			Day			Year		

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

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

Is there Documentation of the disability and severity on file?

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

Currently receiving services/treatment for this disability?

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

MENTAL HEALTH CONDITION

☐	No	☐	Yes	Date Information Collected:			/			/				
						Month			Day			Year		

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

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

Is there Documentation of the disability and severity on file?

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

Currently receiving services/treatment for this disability?

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

PHYSICAL CONDITION

☐	No	☐	Yes	Date Information Collected:			/			/				

Month Day Year

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

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

Is there Documentation of the disability and severity on file?

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

Currently receiving services/treatment for this disability?

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

INSURANCE INFORMATION *PROOF NEEDED*

COVERED BY HEALTH INSURANCE?

☐	No	☐	Yes	Date Information Collected:			/			/				

HEALTH INSURANCE PROVIDERS

NO	YES		NO	YES	
☐	☐	MEDICAID	☐	☐	Health Insurance obtained through COBRA
☐	☐	MEDICARE	☐	☐	Private Pay Health Insurance
☐	☐	State Children's Health Insurance Program (or use local name)	☐	☐	State Health Insurance for Adults (or use local name)
☐	☐	Veteran's Administration (VA) Medical Services	☐	☐	Indian Health Services Program
☐	☐	Veteran's Administration (VA) Medical Services	☐	☐	Other
☐	☐	Employer – Provided Health Insurance			

OUTREACH

Date of Engagement:

		/			/				

Month Day Year

Date of Contact

		/			/				

Month Day Year

Start Date

		/			/				

Month Day Year

End Date:

		/			/				

Month Day Year

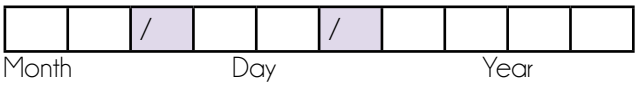
Housing Move In Date

		/			/				

Month Day Year

Connection to SOAR

☐	No	☐	Yes	☐	Client doesn't know	☐	Client refused	☐	Data not collected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Month
Day
Year