**NEBRASKA INTERIM ASSESSMENT**

|  |
| --- |
| **TYPE OF INTERIM** |
|  | Update |  | Annual Assessment |

|  |
| --- |
| **DATE OF INTERIM ASSESSMENT** |
|  |  | **/** |  |  | **/** |  |  |  |  |

Month Day Year

|  |  |  |
| --- | --- | --- |
| **CLIENT NAME** |   | **HMIS CLIENT ID - For HMIS Users only** |
|  |   |  |  |  |  |  |  |  |  |  |

|  |
| --- |
| **CLIENT LOCATION – In which CoC is the Head of Household staying at the time of project entry?** |
| * NE-500 BOS (Anywhere in Nebraska outside of Lincoln/Omaha)
 | * NE-502 Lincoln
 |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **HOUSING MOVE-IN DATE (RRH & PH)** |  |  | **/** |  |  | **/** |  |  |  |  |
|  | Month |  | Day |  | Year |

|  |
| --- |
| **INCOME AND SOURCES - Does the client currently have any income from any source?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |
| **To complete the table below, you must answer ‘Yes’ or ‘No’ for each income source.**Answer ‘Yes’ only if the income source is current and received as of today (i.e. not terminated).Answer ‘No’ for sources that have been terminated, even if they were received in the past.**If the response for any source is ‘Yes’, complete the shaded sections below.**Enter the start date and monthly amount received. If unsure of the exact amount, enter the client’s best estimate.Children's income (except earned income) can be included under the Head of Household’s information. |
| **Source of Income** | **Yes** | **No** | **If yes, monthly amount from source** **(round to nearest dollar)** |
| AABD (Aid to Aged, Blind & Disabled) |  |  | $ |
| Alimony or Other Spousal Support |  |  | $ |
| Annuities |  |  | $ |
| Child Support |  |  | $ |
| Contributions from Other People |  |  | $ |
| Dividends (Investments) |  |  | $ |
| Earned Income (from job) |  |  | $ |
| General Assistance |  |  | $ |
| Interest (Bank) |  |  | $ |
| Pension or Retirement Income from a Former Job |  |  | $ |
| Private Disability Insurance |  |  | $ |
| Rental Income |  |  | $ |
| Retirement Income from Social Security |  |  | $ |
| Self Employment Wages |  |  | $ |
| SSA |  |  | $ |
| SSDI |  |  | $ |
| SSI |  |  | $ |
| State Disability |  |  | $ |
| Stipend |  |  | $ |
| TANF |  |  | $ |
| Unemployment Insurance |  |  | $ |
| VA Non-service Connected Disability Pension |  |  | $ |
| VA Service Connected Disability Compensation |  |  | $ |
| Worker’s Compensation |  |  | $ |
| Other (specify): |  |  | $ |
| **Total monthly income from all sources** | $ |

|  |
| --- |
| **NON-CASH BENEFITS - Does the client have any non-cash benefits from any source?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |
| **To complete the table below, you must answer ‘Yes’ or ‘No’ for each non-cash benefit.** Answer ‘Yes’ only if the non-cash benefit is recurrent and received as of today (i.e. not terminated). Answer ‘No’ for non-cash benefits that have been terminated, even if they were received in the past.**If the response for any non-cash benefit is ‘Yes’, complete the shaded section.** |
| **Source of Non-Cash Benefit** | **Yes** | **No** | **If yes, monthly amount from source****(round to nearest dollar)** |
| LIHEAP |  |  | $ |
| Supplemental Nutrition Assistance Program (SNAP) |  |  | $ |
| Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) |  |  | $ |
| TANF Child Care Services  |  |  | $ |
| TANF Transportation Services  |  |  | $ |
| Other TANF-funded Services  |  |  | $ |
| Other (specify): |  |  | $ |

|  |
| --- |
| **HEALTH INSURANCE - Is the client currently covered by health insurance?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |
| **Answer ‘Yes’ or ‘No’ for each health insurance source.**Answer ‘Yes’ for any source that is currently received.Answer ‘No’ for sources that have been terminated, even if they were received in the past. If the client selects ‘Yes’ for any insurance type, complete the shaded section below. |
| **Health Insurance Type** | **Yes** | **No** |
| 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 (specify): |  |  |

|  |
| --- |
| **DISABILITY STATUS - Does the client have a disabling condition?** |
|  | Yes |   |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |
| **Answer ‘Yes’ or ‘No’ for each disability type (in white).**If the client selects ‘Yes’ for any disability type, you must also complete the shaded sections below. |
| **Disability Type** | **Yes** | **No** | **Expected to be of long-continued and indefinite duration and** **substantially impairs client’s ability to live independently?** |
| Alcohol Abuse |  |  |  Yes |  No |  CDK |  CR |  DNC |
| Drug Abuse |  |  |  Yes |  No |  CDK |  CR |  DNC |
| Both Alcohol and Drug Abuse |  |  |  Yes |  No |  CDK |  CR |  DNC |
| Developmental Disability |  |  |  Yes |  No |  CDK |  CR |  DNC |
| HIV/AIDS |  |  |  Yes |  No |  CDK |  CR |  DNC |
| Mental Health Problem |  |  |  Yes |  No |  CDK |  CR |  DNC |
| Physical Disability |  |  |  Yes |  No |  CDK |  CR |  DNC |
| Chronic Health Condition |  |  |  Yes |  No |  CDK |  CR |  DNC |

|  |
| --- |
| **DOMESTIC VIOLENCE - Is client a domestic violence victim/survivor?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |

# 

|  |
| --- |
| **If YES, when did the experience occur?** |
|  | Within the past three months |  | Client doesn’t know |
|  | Three to six months ago (excluding six months exactly) |  | Client refused |
|  | Six months to one year ago (excluding one year exactly) |  | Data not collected |
|  | More than a year ago |   |



|  |
| --- |
| **If YES, is the client currently fleeing?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |

|  |
| --- |
| **CURRENT LIVING SITUATION** |
| **Homeless** |  | Place not meant for habitation (e.g. a vehicle, abandoned building, bus/train station, airport or anywhere outside) |
|  | Emergency shelter, including hotel or motel paid for with emergency shelter voucher or RHY-funded Host Home shelter |
|  | Safe Haven |
| **Institutional** |  | Foster care home or foster care group home |
|  | Hospital or other residential non-psychiatric medical facility |
|  | Jail, prison or juvenile detention facility |
|  | Long-term care facility or nursing home |
|  | Psychiatric hospital or other psychiatric facility |
|  | Substance abuse treatment facility or detox center |
| **Temporary and Permanent Housing** |  | Residential project or halfway house with no homeless criteria |
|  | Hotel or motel paid for without emergency shelter voucher |
|  | Transitional housing for homeless persons (including homeless youth) |
|  | Host Home (non-crisis) |
|  | Staying or living in a friend’s room, apartment or house |
|  | Staying or living in a family member’s room, apartment or house |
|  | Rental by client, with GPD TIP housing subsidy |
|  | Rental by client, with VASH housing subsidy |
|  | Permanent housing (other than RRH) for formerly homeless persons |
|  | Rental by client, with RRH or equivalent subsidy |
|  | Rental by client with HVC voucher (tenant or project based) |
|  | Rental by client in a public housing unit |
|  | Rental by client, no ongoing housing subsidy |
|  | Rental by client with other ongoing housing subsidy |
|  | Owned by client with ongoing housing subsidy |
|  | Owned by client, no ongoing housing subsidy |
| **Other** |  | Other (specify): |
|  | Worker unable to determine |
|  | Client doesn’t know |
|  | Client refused |
|  | Data not collected |
| **Living Situation Verified By:** |
|  | NE-500 Balance of State |  | NE-501 Omaha/MACCH |  | NE-502 Lincoln |
| **Is client going to have to leave their current living situation within 14 days?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |
| **If leaving within 14 days, has a subsequent residence been identified?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |
| **If leaving within 14 days, does individual or family have resources or support networks to obtain other permanent housing?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |
| **If leaving within 14 days, has the client had a lease or ownership interest in a permanent housing unit in the last 60 days?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |
| **If leaving within 14 days, has the client moved 2 or more times in the last 60 days?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |
| **DATE OF ENGAGEMENT** |  |  | **/** |  |  | **/** |  |  |  |  |
|  | Month |  | Day |  | Year |

**UPDATE FOR CHILDREN IN THE HOUSEHOLD**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Last Name** | **First Name** | **MI** | **Suffix** | **See Codes Below** |
| **Covered by Health Insurance?\*** | **Disabling Condition****\*** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **\* Health Insurance:** **Y**=Yes **N**=No **DK**=Client Doesn’t Know **CR**=Client Refused **If YES, check all that apply:** Medicaid  Medicare  CHIP  Veteran’s Affairs  Employer  COBRA  Private Pay  Indian Health Services  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **\* Disabling Condition:** **Y**=Yes **N**=No **DK**=Client Doesn’t Know **CR**=Client Refused **If YES, check all that apply:** Alcohol Abuse  Drug Abuse  Both Alcohol & Drug Abuse  Developmental Disability  HIV/AIDS  Mental Health Problem  Physical  Chronic Health Condition  |