DRH Interim Assessment

Date Interim Assessment:_____ Disaster Re-Housing Agency:_____

HMIS #:_____ County (where are you staying now): _____

A. Identification Data

1. First Name	Last Name	Middle Initial

2. What is your FEMA ID number? _____

3. Primary Phone Number: _____
   □ Client does not know □Client refused

4. Email Address: _____
   □ Client does not know □Client refused

5. Emergency Contact Name: _____
   □ Client does not know □Client refused

6. Emergency Contact Phone: _____
   □ Client does not know □Client refused

7. Emergency Contact Email Address: _____
   □ Client does not know □Client refused

B. Back@Home Housing Information

1. Housing Move-In Date:
   _____/_____/_____

2. Lease Start Date:
   _____/_____/_____

3. Lease End Date:
   _____/_____/_____

4. Apartment Complex name (if applicable):
   _____
   ☐ Client does not know ☐Client refused

5. Back@Home Housing address (include apartment number, street address, city, county, state, zip):
   _____

6. Landlord Name: _____

7. Landlord Phone Number: _____

8. Number of bedrooms in unit: _____

   ☐ Client does not know ☐Client refused

9. Monthly Rental Amount: _____

   ☐ Client does not know ☐Client refused

10. Type of Unit:

    ☐ Apartment ☐ Mobile home ☐ Shared housing (Shared unit/room/facilities)

    ☐ Single family home ☐Client does not know ☐Client refused

11. ADA Unit? ☐Yes ☐No

12. Do you have a service animal?

    ☐Yes ☐No If yes, how many? _____

13. Housing Move-Out Date (if applicable):
    _____/_____/_____

C. Status Updates

1. Any changes to disabling conditions?

   ☐Yes ☐No ☐ Client does not know ☐Client refused

   Answer 'Yes' or 'No' for each disability type. *If the client selects 'Yes' for any disability type, you must also complete the shaded sections below. Disability Determination confirms the client's response and does not require documentation. Add Start and End dates for changes*

Disability Type	Yes	No	Disability Determination	Expected to be of indefinite duration and substantially impairs client's ability to live independently?	Start Date	End Date
Physical	☐	☐	☐Yes ☐Client does not know ☐No ☐Client refused	☐Yes ☐Client does not know ☐No ☐Client refused		
Chronic Health Condition	☐	☐	☐Yes ☐Client does not know ☐No ☐Client refused	☐Yes ☐Client does not know ☐No ☐Client refused		
HIV/AIDS	☐	☐	☐Yes ☐Client does not know ☐No ☐Client refused	☐Yes ☐Client does not know ☐No ☐Client refused		
Developmental	☐	☐	☐Yes ☐Client does not know ☐No ☐Client refused	☐Yes ☐Client does not know ☐No ☐Client refused		

Disability Type	Yes	No	Disability Determination	Expected to be of indefinite duration and substantially impairs client's ability to live independently?	Start Date	End Date
Alcohol Abuse	☐	☐	☐Yes ☐Client does not know ☐No ☐Client refused	☐Yes ☐Client does not know ☐No ☐Client refused		
Drug Abuse	☐	☐	☐Yes ☐Client does not know ☐No ☐Client refused	☐Yes ☐Client does not know ☐No ☐Client refused		
Both Drug and Alcohol Abuse	☐	☐	☐Yes ☐Client does not know ☐No ☐Client refused	☐Yes ☐Client does not know ☐No ☐Client refused		
Mental Health Problem	☐	☐	☐Yes ☐Client does not know ☐No ☐Client refused	☐Yes ☐Client does not know ☐No ☐Client refused		

2. Any changes to health insurance?

   ☐Yes ☐No ☐ Client does not know ☐Client refused

   Answer 'Yes' or 'No' for each Health Insurance Type. *Add Start and End Dates for changes*

Health Insurance Type	Yes	No	Start Date	End Date
Medicaid	☐	☐		
Medicare	☐	☐		
State Children's Health Insurance Program (or use local name)	☐	☐		
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 If Yes, specify source:	☐	☐		

3. Any changes to income?

   ☐Yes ☐No ☐ Client does not know ☐Client refused

   Answer 'Yes' or 'No' for each income source. *If the client selects 'Yes' for any income source, you must also complete the shaded sections below. Add Start and End Dates for changes*

Source of Income	Yes	No	If yes, monthly amount from source	Start Date	End Date
Earned income (i.e., employment income)	☐	☐	$		
Unemployment Insurance	☐	☐	$		
Supplemental Security Income (SSI)	☐	☐	$		
Social Security Disability Income (SSDI)	☐	☐	$		

Source of Income	Yes	No	If yes, monthly amount from source	Start Date	End Date
VA Service-Connected Disability	☐	☐	$		
VA Non-Service-Connected Disability	☐	☐	$		
Private disability insurance	☐	☐	$		
Worker's Compensation	☐	☐	$		
Temporary Assistance for Needy Families	☐	☐	$		
General Assistance (GA)	☐	☐	$		
Retirement Income from Social Security	☐	☐	$		
Pension or retirement income from a	☐	☐	$		
Child support	☐	☐	$		
Alimony or other spousal support	☐	☐	$		
Other source:	☐	☐	$		
Total monthly income from all sources			$		

4. Any changes to non-cash benefits?

   ☐Yes ☐No ☐ Client does not know ☐Client refused

   Answer 'Yes' or 'No' for each non-cash benefit. *Add Start and End Date for changes*

Source of Non-Cash Benefit	Yes	No	Start Date	End Date
Supplemental Nutrition Assistance Program (SNAP)	☐	☐		
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	☐	☐		
TANF Child Care services *(or use local name)*	☐	☐		
TANF transportation services *(or use local name)*	☐	☐		
Other TANF-Funded Services *(or use local name)*	☐	☐		
Other source:	☐	☐		