

**4.4 HEALTH INSURANCE
(ALL CLIENTS)**

Is the client currently covered by health insurance?

No

Yes

Client doesn't know

Client refused



[IF YES] Answer 'Yes' or 'No' for each health insurance source.

Answer 'No' for sources that have been terminated, even if they were received in the past.

No	Yes	Type of health insurance
<input type="checkbox"/>	<input type="checkbox"/>	Private
<input type="checkbox"/>	<input type="checkbox"/>	Private - Employer
<input type="checkbox"/>	<input type="checkbox"/>	Private - Individual
<input type="checkbox"/>	<input type="checkbox"/>	Medicare
<input type="checkbox"/>	<input type="checkbox"/>	Medicaid (Medi-Cal)
<input type="checkbox"/>	<input type="checkbox"/>	State Children's Health Insurance Program S-CHIP
<input type="checkbox"/>	<input type="checkbox"/>	Military Insurance
<input type="checkbox"/>	<input type="checkbox"/>	Other Public
<input type="checkbox"/>	<input type="checkbox"/>	State Funded
<input type="checkbox"/>	<input type="checkbox"/>	Combined Children's Health Insurance / Medicaid Program
<input type="checkbox"/>	<input type="checkbox"/>	Indian Health Service (IHS)
<input type="checkbox"/>	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	No insurance

**4.10 ALCOHOL ABUSE PROBLEM
(ALL CLIENTS)**

Does the client currently have an alcohol abuse problem?

No

Yes

Client doesn't know

Client refused



[IF YES for alcohol abuse problem] Is client currently receiving services/treatment for this condition?

No

Yes

Client doesn't know

Client refused

[IF YES for alcohol abuse problem] Is the alcohol abuse problem expected to be of long-continued and indefinite duration and substantially impairs client's ability to live independently?

No

Yes

Client doesn't know

Client refused

[IF YES for alcohol abuse problem] Is documentation of the disability and severity on file?

No

Yes

**4.7 CHRONIC HEALTH CONDITION
(ALL CLIENTS)**

Does the client currently have a chronic health condition?

No
 Yes

Client doesn't know
 Client refused



[IF YES for chronic health condition] Is the client currently receiving services/treatment for this condition?

No
 Yes

Client doesn't know
 Client refused

[IF YES for chronic health condition] Is the chronic health condition expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

No
 Yes

Client doesn't know
 Client refused

[IF YES for chronic health condition] Is documentation of the disability and severity on file?

No
 Yes

**4.6 DEVELOPMENTAL DISABILITY
(ALL CLIENTS)**

Does the client currently have a developmental disability?

No
 Yes

Client doesn't know
 Client refused



[IF YES for developmental disability] Is the client currently receiving services/treatment for this disability?

No
 Yes

Client doesn't know
 Client refused

[IF YES for developmental disability] Is the developmental disability expected to substantially impair the client's ability to live independently?

No
 Yes

Client doesn't know
 Client refused

[IF YES for developmental disability] Is documentation of the disability and severity on file?

No
 Yes

**4.10 DRUG ABUSE PROBLEM
(ALL CLIENTS)**

Does the client currently have a drug abuse problem?

- No
 Yes

- Client doesn't know
 Client refused



[IF YES for drug abuse problem] Is client currently receiving services/treatment for this condition?

- No
 Yes

- Client doesn't know
 Client refused

[IF YES for drug abuse problem] Is the drug abuse problem expected to be of long-continued and indefinite duration and substantially impairs client's ability to live independently?

- No
 Yes

- Client doesn't know
 Client refused

[IF YES for drug abuse problem] Is documentation of the disability and severity on file?

- No
 Yes

**4.8 HIV/AIDS
(ALL CLIENTS)**

Does the client currently have HIV/AIDS?

- No
 Yes

- Client doesn't know
 Client refused



[IF YES for HIV/AIDS] Is the client currently receiving services/treatment for this condition?

- No
 Yes

- Client doesn't know
 Client refused

[IF YES for HIV/AIDS] Is HIV/AIDS expected to substantially impair the client's ability to live independently?

- No
 Yes

- Client doesn't know
 Client refused

[IF YES for HIV/AIDS] Is documentation of the disability and severity on file?

- No
 Yes

**4.9 MENTAL HEALTH ILLNESS
(ALL CLIENTS)**

Does the client currently have a mental health illness?

No
 Yes

Client doesn't know
 Client refused



[IF YES for mental health illness] Is the client currently receiving services/treatment for this condition?

No
 Yes

Client doesn't know
 Client refused

[IF YES for mental health illness] Is the mental health illness expected to be of long-continued and indefinite duration and substantially impairs the client's ability to live independently?

No
 Yes

Client doesn't know
 Client refused

[IF YES for mental health illness] Is documentation of the disability and severity on file?

No
 Yes

**4.5 PHYSICAL DISABILITY
(ALL CLIENTS)**

Does the client currently have a physical disability?

No
 Yes

Client doesn't know
 Client refused



[IF YES for physical disability] Is the client currently receiving services/treatment for this disability?

No
 Yes

Client doesn't know
 Client refused

[IF YES for physical disability] Is the physical disability expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

No
 Yes

Client doesn't know
 Client refused

[IF YES for physical disability] Is documentation of the disability and severity on file?

No
 Yes

4.11 DOMESTIC VIOLENCE
(HEAD OF HOUSEHOLD AND OTHER ADULTS ONLY)

Is client a domestic violence victim/survivor?

- No
- Yes

- Client doesn't know
- Client refused



[IF YES for domestic violence] When did the experience occur?

- Within the past three months
- Three to six months ago (excluding six months exactly)
- Six months to one year ago (excluding one year exactly)

- One year ago or more
- Client doesn't know
- Client refused

[IF YES for domestic violence] Is client currently fleeing?

- Yes
- No

- Client doesn't know
- Client refused

4.2 INCOME AND SOURCES
(HEAD OF HOUSEHOLD AND OTHER ADULTS ONLY)

Income from any source?

No

Yes

Client doesn't know

Client refused



[IF YES] Answer Yes or No for each income source. If the response for a source is 'Yes', enter the monthly amount received based on current income. If unsure of the exact monthly amount, enter client's best estimate.

Source of income	Receiving income from source?	If yes, monthly amount from source (round to nearest dollar)
Earned income (i.e., employment income)	No <input type="checkbox"/>	
	Yes <input type="checkbox"/>	\$. 0 0
Unemployment Insurance	No <input type="checkbox"/>	
	Yes <input type="checkbox"/>	\$. 0 0
Supplemental Security Income (SSI)	No <input type="checkbox"/>	
	Yes <input type="checkbox"/>	\$. 0 0
Social Security Disability Income (SSDI)	No <input type="checkbox"/>	
	Yes <input type="checkbox"/>	\$. 0 0
VA Service-Connected Disability Compensation	No <input type="checkbox"/>	
	Yes <input type="checkbox"/>	\$. 0 0
Private disability insurance	No <input type="checkbox"/>	
	Yes <input type="checkbox"/>	\$. 0 0
Worker's Compensation	No <input type="checkbox"/>	
	Yes <input type="checkbox"/>	\$. 0 0
Temporary Assistance for Needy Families (TANF)	No <input type="checkbox"/>	
	Yes <input type="checkbox"/>	\$. 0 0
General Assistance (GA)	No <input type="checkbox"/>	
	Yes <input type="checkbox"/>	\$. 0 0
Retirement Income from Social Security	No <input type="checkbox"/>	
	Yes <input type="checkbox"/>	\$. 0 0
VA Non-Service-Connected Disability Pension	No <input type="checkbox"/>	
	Yes <input type="checkbox"/>	\$. 0 0
Pension or retirement income from a former job	No <input type="checkbox"/>	
	Yes <input type="checkbox"/>	\$. 0 0
Child support	No <input type="checkbox"/>	
	Yes <input type="checkbox"/>	\$. 0 0
Alimony or other spousal support	No <input type="checkbox"/>	
	Yes <input type="checkbox"/>	\$. 0 0
Other source If yes, specify	No <input type="checkbox"/>	
	Yes <input type="checkbox"/>	\$. 0 0
Total monthly income	Monthly income from all sources	\$. 0 0

4.3 NON-CASH BENEFITS
(HEAD OF HOUSEHOLD AND OTHER ADULTS ONLY)

Non-cash benefits from any source?

No

Yes

Client doesn't know

Client refused



[IF YES] Answer 'Yes' or 'No' for each non-cash benefit source. (Answer 'No' for benefits that have been terminated, even if they were received in the past.) If unsure of the exact monthly amount, enter client's best estimate.

Source of non-cash benefit	Receiving benefit from source?	If yes, monthly amount from source (round to nearest dollar)			
Supplemental Nutrition Assistance Program (SNAP) / Food Stamps	No				
	Yes	\$. 0 0
MEDICAID	No				
	Yes				
MEDICARE	No				
	Yes				
State Children's Health Insurance Program	No				
	Yes				
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	No				
	Yes				
Veteran's Administration Medical Services	No				
	Yes				
TANF Child Care services	No				
	Yes				
TANF transportation services	No				
	Yes				
Other TANF-Funded Services	No				
	Yes				
Section 8, Public Housing, or other ongoing rental assistance	No				
	Yes				
Other source: _____	No				
	Yes				