1. Reassessment Summary

Reassessment Date _____/_____/_____ **Case Manager** _____

Project Name_____ **Client ID** (Computer Generated) _____

2. Client Demographics

First _____ **Middle**_____ **Last** _____ **Suffix**_____

3. Program Specific Information

Covered by Health Insurance	*If Yes, Which Source(s)*	
☐ No	☐ Medicaid (Medi-Cal)	☐ Health Insurance obtained through COBRA
☐ Yes	☐ Medicare	☐ Private Pay Health Insurance
☐ Client Doesn't Know	☐ State Children's Health Insurance Program	☐ State Health Insurance for Adults
☐ Client Refused	☐ VA Medical Services (Military Insurance)	☐ Indian Health Services Program
☐ Data Not Collected	☐ Employer Provided Health Insurance	☐ Other _____

Income From Any Source	*If Yes, Indicate All Sources and Dollar Amounts that Apply*
☐ No	_____ Earned Income
☐ Yes	_____ Unemployment Insurance
☐ Client Doesn't Know	_____ SSI
☐ Client Refused	_____ SSDI
☐ Data Not Collected	_____ VA Service-Connected Disability Compensation
	_____ VA Non-Service-Connected Disability Compensation
	_____ Private Disability Insurance
	_____ Worker's Compensation
	_____ TANF
	_____ General Assistance
	_____ Retirement Income from Social Security
	_____ Pension or Retirement from a Former Job
	_____ Child Support
	_____ Alimony or Other Spousal Support
	_____ Other Source _____

Non-Cash Benefits from Any Source	*If Yes, Indicate All Sources and Dollar Amounts that Apply*
☐ No	_____ Supplemental Nutritional Assistance Program (Food Stamps)
☐ Yes	_____ Special Supplementation Nutritional Program for WIC
☐ Client Doesn't Know	_____ TANF Child Care Services
☐ Client Refused	_____ TANF Transportation Services
☐ Data Not Collected	_____ Other TANF-Funded Services
	_____ Other Source _____