CLARITY HMIS: HUD-CoC STATUS ASSESSMENT FORM

Use block letters for text and bubble in the appropriate circles.

Please complete a separate form for each household member.

CLIENT NAME OR IDENTIFIER: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

PROJECT STATUS DATE​ *​[All Clients]*

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|   |  | / |  |  | / |  |  |  |  |

 Month DayYear

IN PERMANENT HOUSING *​[Permanent Housing Projects, for Head of Household]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Yes |
| **IF “YES” TO PERMANENT HOUSING** |
| **Housing Move-In Date:\*** | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ |
| \**If client moved into permanent housing, make sure to update on the* ***enrollment screen****.* |

PHYSICAL DISABILITY ​*[All Clients]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  | ○ | Data not collected |
| **IF “YES” TO PHYSICAL DISABILITY – SPECIFY**  |
| Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? | ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  |  | ○ | Data not collected |

DEVELOPMENTAL DISABILITY ​*[All Clients]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  | ○ | Data not collected |

CHRONIC HEALTH CONDITION ​*[All Clients]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  | ○ | Data not collected |
| **IF “YES” TO CHRONIC HEALTH CONDITION – SPECIFY**  |
| Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? | ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  |  | ○ | Data not collected |

HIV-AIDS *[All Clients]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  | ○ | Data not collected |

MENTAL HEALTH DISORDER ​*[All Clients]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  | ○ | Data not collected |
| **IF “YES” TO MENTAL HEALTH DISORDER – SPECIFY**  |
| Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? | ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  |  | ○ | Data not collected |

SUBSTANCE USE DISORDER ​*[All Clients]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Client doesn’t know |
| ○ | Alcohol use disorder | ○ | Client prefers not to answer |
| ○ | Drug use disorder | ○ | Data not collected |
| ○ | Both alcohol and drug use disorders |  |
| **IF “ALCOHOL USE DISORDER” “DRUG USE DISORDER” OR “BOTH ALCOHOL AND DRUG USE DISORDERS” – SPECIFY** |
| Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? | ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  |  | ○ | Data not collected |

SURVIVOR OF DOMESTIC VIOLENCE *​[Head of Household and Adults]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  | ○ | Data not collected |
| **IF “YES” TO SURVIVOR OF DOMESTIC VIOLENCE – SPECIFY WHEN EXPERIENCE OCCURRED** |
| ○ | Within the past three months | ○ | Client doesn’t know |
| ○ | Three to six months ago (excluding six months exactly) | ○ | Client prefers not to answer |
| ○ | Six months to one year ago (excluding one year exactly) | ○ | Data not collected |
| ○ | One year ago or more |  |
| **Are you currently fleeing?** | ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  |  | ○ | Data not collected |

INCOME FROM ANY SOURCE *​[Head of Household and Adults]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  | ○ | Data not collected |
| **IF “YES” TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY** |
| **Income Source** | **Amount** | **Income Source** | **Amount** |
| ○ | Earned Income |  | ○ | Temporary Assistance for Needy Families (TANF) |  |
| ○ | Unemployment Insurance |  | ○ | General Assistance (GA) |  |
| ○ | Supplemental Security Income (SSI) |  | ○ | Retirement income from Social Security |  |
| ○ | Social Security Disability Insurance (SSDI) |  | ○ | Pension or retirement income from a former job |  |
| ○ | VA Service-Connected Disability Compensation |  | ○ | Child support |  |
| ○ | VA Non-Service-Connected Disability Pension |  | ○ | Alimony and other spousal **s**upport |  |
| ○ | Private **d**isability **i**nsurance |  | ○ | Other income source *(specify):* |  |
| ○ | Worker’s Compensation |  |
| **Total Monthly Income for Individual:** |

#

RECEIVING NON-CASH BENEFITS​ *​[Head of Household and Adults]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  | ○ | Data not collected |
| **IF “YES” TO NON-CASH BENEFITS – INDICATE ALL SOURCES THAT APPLY** |
| ○ | Supplemental Nutrition Assistance Program (SNAP) | ○ | TANF Child Care Services |
| ○ | Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) | ○ | TANF Transportation Services |
| ○ | Other (specify): | ○ | Other TANF-funded services |

COVERED BY HEALTH INSURANCE ​*[All Clients]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  | ○ | Data not collected |
| **IF “YES” TO HEALTH INSURANCE** – **HEALTH INSURANCE COVERAGE DETAILS** |
| ○ | MEDICAID | ○ | Employer Provided Health Insurance |
| ○ | MEDICARE | ○ | Health Insurance Obtained Through COBRA |
| ○ | State Children’s Health Insurance (SCHIP) | ○ | Private Pay Health Insurance |
| ○ | Veteran’s Health Administration (VHA) | ○ | State Health Insurance for Adults |
| ○ | Other (specify): | ○ | Indian Health Services Program |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of applicant stating all information is true and correct Date