CLARITY HMIS: HUD-HOPWA PROJECT ENROLLMENT 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 START DATE​ *​*​ *​[All Clients]*

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

 Month DayYear

TRANSLATION ASSISTANCE NEEDED? *[Head of Household]*

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

IF “YES” TO TRANSLATION ASSISTANCE NEEDED – INDICATE PREFERRED LANGUAGE

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | *Insert language option* | ○ | *Insert language option* |
| ○ | *Insert language option* | ○ | *Insert language option* |
| ○ | *Insert language option* | ○ | *Insert language option* |
| ○ | *Insert language option* | ○ | *Insert language option* |
| ○ | *Insert language option* | ○ | *Insert language option* |
| ○ | *Insert language option* | ○ | *Insert language option* |
| ○ | *Insert language option* | ○ | *Insert language option* |
| ○ | *Insert language option* | ○ | *Insert language option* |
| ○ | *Insert language option* | ○ | *Insert language option* |
| ○ | *Insert language option* | ○ | *Insert language option* |
| ○ | Different Preferred Language (*specify*): | ○ | Client doesn’t know |
| ○ | Client prefers not to answer |
| ○ | Data not collected |

RELATIONSHIP TO HEAD OF HOUSEHOLD ​*[All Client Households]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | Self | ○ | Head of household - other relation to member  |
| ○ | Head of household’s child | ○ | Other: non­relation member |
| ○ | Head of household’s spouse or partner |  |

ENROLLMENT CoC *[only if multiple CoC’s] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Yes |
| IF “YES” TO PERMANENT HOUSING |
| Housing Move-In Date: | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ |

PRIOR LIVING SITUATION

TYPE OF RESIDENCE *[Head of Household and Adults]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport, or anywhere outside) | ○ | Hotel or motel paid for without emergency shelter voucher |
| ○ | Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or Host Home shelter | ○ | Host Home (non-crisis) |
| ○ | Safe Haven | ○ | Staying or living in a friend’s room, apartment, or house |
| ○ | Foster care home or foster care group home | ○ | Staying or living in a family member’s room, apartment or house |
| ○ | Hospital or other residential non­psychiatric medical facility | ○ | Rental by client, no ongoing housing subsidy |
| ○ | Jail, prison or juvenile detention facility | ○ | Rental by client, with ongoing housing subsidy |
| ○ | Long-term care facility or nursing home | ○ | Owned by client, with on­going housing subsidy |
| ○ | Psychiatric hospital or other psychiatric facility | ○ | Owned by client, no on­going housing subsidy |
| ○ | Substance abuse treatment facility or detox center | ○ | Client doesn’t know |
| ○ | Transitional housing for homeless persons (including homeless youth) | ○ | Client prefers not to answer |
| ○ | Residential project or halfway house with no homeless criteria | ○ | Data not collected |

|  |
| --- |
|  IF “RENTAL BY CLIENT, WITH ONGOING HOUSING SUBSIDY” – SPECIFY: |
| ○ | GPD TIP housing subsidy | ○ | Emergency Housing Voucher |
| ○ | VASH Housing subsidy | ○ | Family Unification Program Voucher (FUP) |
| ○ | RRH or equivalent subsidy | ○ | Foster Youth to Independence Initiative (FYI) |
| ○ | HCV voucher (tenant or project based) (not dedicated) | ○ | Permanent Supportive Housing |
| ○ | Public Housing Unit | ○ | Other permanent housing dedicated for formerly homeless persons |
| ○ | Rental by client, with other ongoing housing subsidy |

LENGTH OF STAY IN PRIOR LIVING SITUATION

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ○ | One night or less | ○ | One month or more, but less than 90 days | ○ | Client doesn’t know |
| ○ | Two to six nights | ○ | 90 days or more, but less than one year | ○ | Client prefers not to answer |
| ○ | One week or more, but less than one month | ○ | One year or longer | ○ | Data not collected  |

LENGTH OF STAY LESS THAN 7 NIGHTS *[TH, PH]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Yes |

LENGTH OF STAY LESS THAN 90 DAYS [*Institutional Housing Situations]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Yes |

ON THE NIGHT BEFORE – STAYED ON THE STREETS, EMERGENCY SHELTER, SAFE HAVEN *[Head of Household and Adults]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | Yes | ○ | No |
| Approximate Date This Episode of Homelessness Started | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ |
| Number of *times* the client has been on the streets, ES, or Safe Haven in the last 3 years |
| ○ | One Time | ○ | Client doesn’t know |
| ○ | Two Times | ○ | Client prefers not to answer |
| ○ | Three Times | ○ | Data not collected |
| ○ | Four or More Times |  |
| Total Number of *Months* homeless on the streets, ES, or Safe Haven in the last 3 years |
| ○ | One month (this time is the first month) | ○ | Client doesn’t know |
| ○ | 2­12 months (specify number of months): \_\_\_\_\_\_\_\_ | ○ | Client prefers not to answer |
| ○ | More than 12 months | ○ | Data not collected |

DISABLING CONDITION ​*[All Clients]*

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

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 support |  |
| ○ | Private disability insurance |  | ○ | 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 & REASONS NOT COVERED BY NON-CHOSEN SELECTION(S) |
| ○ | MEDICAID | ○ | Applied; decision pending |
| ○ | Applied; client not eligible |
| ○ | Client did not apply |
| ○ | Insurance type N/A for this client |
| ○ | Client doesn’t know |
| ○ | Client prefers not to answer |
| ○ | Data not collected |
| ○ | MEDICARE  | ○ | Applied; decision pending |
| ○ | Applied; client not eligible |
| ○ | Client did not apply |
| ○ | Insurance type N/A for this client |
| ○ | Client doesn’t know |
| ○ | Client prefers not to answer |
| ○ | Data not collected |
| ○ | State Children’s Health Insurance (SCHIP)  | ○ | Applied; decision pending |
| ○ | Applied; client not eligible |
| ○ | Client did not apply |
| ○ | Insurance type N/A for this client |
| ○ | Client doesn’t know |
| ○ | Client prefers not to answer |
| ○ | Data not collected |
| ○ | Veteran’s Health Administration (VHA) | ○ | Applied; decision pending |
| ○ | Applied; client not eligible |
| ○ | Client did not apply |
| ○ | Insurance type N/A for this client |
| ○ | Client doesn’t know |
| ○ | Client prefers not to answer |
| ○ | Data not collected |
| ○ | Employer Provided Health Insurance | ○ | Applied; decision pending |
| ○ | Applied; client not eligible |
| ○ | Client did not apply |
| ○ | Insurance type N/A for this client |
| ○ | Client doesn’t know |
| ○ | Client prefers not to answer |
| ○ | Data not collected |
| ○ | Health Insurance Obtained through COBRA | ○ | Applied; decision pending |
| ○ | Applied; client not eligible |
| ○ | Client did not apply |
| ○ | Insurance type N/A for this client |
| ○ | Client doesn’t know |
| ○ | Client prefers not to answer |
| ○ | Data not collected |
| ○ | Private Pay Health Insurance | ○ | Applied; decision pending |
| ○ | Applied; client not eligible |
| ○ | Client did not apply |
| ○ | Insurance type N/A for this client |
| ○ | Client doesn’t know |
| ○ | Client prefers not to answer |
| ○ | Data not collected |
| ○ | State Health Insurance for Adults | ○ | Applied; decision pending |
| ○ | Applied; client not eligible |
| ○ | Client did not apply |
| ○ | Insurance type N/A for this client |
| ○ | Client doesn’t know |
| ○ | Client prefers not to answer |
| ○ | Data not collected |
| ○ | Indian Health Services Program | ○ | Applied; decision pending |
| ○ | Applied; client not eligible |
| ○ | Client did not apply |
| ○ | Insurance type N/A for this client |
| ○ | Client doesn’t know |
| ○ | Client prefers not to answer |
| ○ | Data not collected |
| ○ | Other Health Insurance (specify) |  |

IF “YES” TO HIV-AIDS:

Receiving AIDS Drug Assistance Program (ADAP)

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  | ○ | Data not collected |
| IF “NO” TO RECEIVING AIDS DRUG ASSISTANCE PROGRAM (ADAP) – SPECIFY REASON |
| ○ | Applied; decision Pending | ○ | Client doesn’t know |
| ○ | Applied; client not eligible | ○ | Client prefers not to answer |
| ○ | Client did not apply | ○ | Data not collected |
| ○ | Insurance type N/A for this client |  |

Receiving Ryan White-funded Medical or Dental Assistance

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  | ○ | Data not collected |
| IF “NO” TO RECEIVING RYAN WHITE-FUNDED MEDICAL OR DENTAL ASSISTANCE – SPECIFY REASON |
| ○ | Applied; decision pending | ○ | Client doesn’t know |
| ○ | Applied; client not eligible | ○ | Client prefers not to answer |
| ○ | Client did not apply | ○ | Data not collected |
| ○ | Insurance type N/A for this client |  |

T-cell (CD4) Count Available

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

T-cell Count (Integer between 0-1500): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How Was the Information Obtained?

|  |  |
| --- | --- |
| ○ | Medical Report |
| ○ | Client report |
| ○ | Other (specify) |

Viral Load Information Available

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | Not available | ○ | Client doesn’t know |
| ○ | Available | ○ | Client prefers not to answer |
| ○ | Undetectable | ○ | Data not collected |

Count (Integer between 0-999999): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 How Was the Information Obtained?

|  |  |
| --- | --- |
| ○ | Medical Report |
| ○ | Client report |
| ○ | Other (specify) |

Has the participant been prescribed anti-retroviral drugs?

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

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

Signature of applicant stating all information is true and correct Date