**CLARITY HMIS: VA SERVICES STATUS FORM**

**(Including HUD VASH, SSVF, GPD)**

**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**

**PHYSICAL DISABILITY ​***[not required for SSVF]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | 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** ​*[not required for SSVF]*

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

**CHRONIC HEALTH CONDITION** ​*[not required for SSVF]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | 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** ​*[not required for SSVF]*

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

**MENTAL HEALTH DISORDER** ​*[not required for SSVF]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | 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** ​*[not required for SSVF]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | 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: |

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**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 |

**CONNECTION WITH SOAR ​***[Heads of Household and Adults, SSVF Rapid Rehousing and Homelessness Prevention]*

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

**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.* |

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**Signature of applicant stating all information is true and correct Date**