

Agency Name: _____



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			Day			Year		

TRANSLATION ASSISTANCE NEEDED? *[Head of Household]*

<input type="radio"/> No	<input type="radio"/> Client doesn't know
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
	<input type="radio"/> Data not collected

IF "YES" TO TRANSLATION ASSISTANCE NEEDED – INDICATE PREFERRED LANGUAGE

<input type="radio"/> <i>Insert language option</i>	<input type="radio"/> <i>Insert language option</i>
<input type="radio"/> <i>Insert language option</i>	<input type="radio"/> <i>Insert language option</i>
<input type="radio"/> <i>Insert language option</i>	<input type="radio"/> <i>Insert language option</i>
<input type="radio"/> <i>Insert language option</i>	<input type="radio"/> <i>Insert language option</i>
<input type="radio"/> <i>Insert language option</i>	<input type="radio"/> <i>Insert language option</i>
<input type="radio"/> <i>Insert language option</i>	<input type="radio"/> <i>Insert language option</i>
<input type="radio"/> <i>Insert language option</i>	<input type="radio"/> <i>Insert language option</i>
<input type="radio"/> <i>Insert language option</i>	<input type="radio"/> <i>Insert language option</i>
<input type="radio"/> <i>Insert language option</i>	<input type="radio"/> <i>Insert language option</i>
<input type="radio"/> <i>Insert language option</i>	<input type="radio"/> <i>Insert language option</i>
<input type="radio"/> <i>Insert language option</i>	<input type="radio"/> <i>Insert language option</i>
<input type="radio"/> Different Preferred Language (<i>specify</i>):	<input type="radio"/> Client doesn't know
	<input type="radio"/> Client prefers not to answer
	<input type="radio"/> Data not collected

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

<input type="radio"/> Self	<input type="radio"/> Head of household - other relation to member
<input type="radio"/> Head of household's child	<input type="radio"/> Other: non-relation member
<input type="radio"/> Head of household's spouse or partner	

ENROLLMENT CoC *[only if multiple CoC's]* _____

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

<input type="radio"/> No	<input type="radio"/> Yes
IF "YES" TO PERMANENT HOUSING	
Housing Move-In Date:	____/____/____

PRIOR LIVING SITUATION

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

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

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

LENGTH OF STAY IN PRIOR LIVING SITUATION

<input type="radio"/>	One night or less	<input type="radio"/>	One month or more, but less than 90 days	<input type="radio"/>	Client doesn’t know
<input type="radio"/>	Two to six nights	<input type="radio"/>	90 days or more, but less than one year	<input type="radio"/>	Client prefers not to answer
<input type="radio"/>	One week or more, but less than one month	<input type="radio"/>	One year or longer	<input type="radio"/>	Data not collected

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

<input type="radio"/>	No	<input type="radio"/>	Yes
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LENGTH OF STAY LESS THAN 90 DAYS [*Institutional Housing Situations*]

<input type="radio"/>	No	<input type="radio"/>	Yes
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ON THE NIGHT BEFORE – STAYED ON THE STREETS, EMERGENCY SHELTER, SAFE HAVEN
[Head of Household and Adults]

<input type="radio"/> Yes	<input type="radio"/> No
Approximate Date This Episode of Homelessness Started	____/____/____
Number of <i>times</i> the client has been on the streets, ES, or Safe Haven in the last 3 years	
<input type="radio"/> One Time	<input type="radio"/> Client doesn't know
<input type="radio"/> Two Times	<input type="radio"/> Client prefers not to answer
<input type="radio"/> Three Times	<input type="radio"/> Data not collected
<input type="radio"/> Four or More Times	
Total Number of <i>Months</i> homeless on the streets, ES, or Safe Haven in the last 3 years	
<input type="radio"/> One month (this time is the first month)	<input type="radio"/> Client doesn't know
<input type="radio"/> 2-12 months (specify number of months): _____	<input type="radio"/> Client prefers not to answer
<input type="radio"/> More than 12 months	<input type="radio"/> Data not collected

DISABLING CONDITION *[All Clients]*

<input type="radio"/> No	<input type="radio"/> Client doesn't know
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
	<input type="radio"/> Data not collected

PHYSICAL DISABILITY *[All Clients]*

<input type="radio"/> No	<input type="radio"/> Client doesn't know	
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer	
	<input type="radio"/> 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?	<input type="radio"/> No	<input type="radio"/> Client doesn't know
	<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
		<input type="radio"/> Data not collected

DEVELOPMENTAL DISABILITY *[All Clients]*

<input type="radio"/> No	<input type="radio"/> Client doesn't know
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
	<input type="radio"/> Data not collected

CHRONIC HEALTH CONDITION *[All Clients]*

<input type="radio"/> No	<input type="radio"/> Client doesn't know	
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer	
	<input type="radio"/> 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?	<input type="radio"/> No	<input type="radio"/> Client doesn't know
	<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
		<input type="radio"/> Data not collected

HIV-AIDS *[All Clients]*

<input type="radio"/> No	<input type="radio"/> Client doesn't know
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
	<input type="radio"/> Data not collected

MENTAL HEALTH DISORDER *[All Clients]*

<input type="radio"/> No	<input type="radio"/> Client doesn't know	
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer	
	<input type="radio"/> 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?	<input type="radio"/> No	<input type="radio"/> Client doesn't know
	<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
		<input type="radio"/> Data not collected

SUBSTANCE USE DISORDER *[All Clients]*

<input type="radio"/> No	<input type="radio"/> Client doesn't know	
<input type="radio"/> Alcohol use disorder	<input type="radio"/> Client prefers not to answer	
<input type="radio"/> Drug use disorder	<input type="radio"/> Data not collected	
<input type="radio"/> 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?	<input type="radio"/> No	<input type="radio"/> Client doesn't know
	<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
		<input type="radio"/> Data not collected

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

<input type="radio"/> No	<input type="radio"/> Client doesn't know	
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer	
	<input type="radio"/> Data not collected	
IF "YES" TO SURVIVOR OF DOMESTIC VIOLENCE – SPECIFY WHEN EXPERIENCE OCCURRED		
<input type="radio"/> Within the past three months	<input type="radio"/> Client doesn't know	
<input type="radio"/> Three to six months ago (excluding six months exactly)	<input type="radio"/> Client prefers not to answer	
<input type="radio"/> Six months to one year ago (excluding one year exactly)	<input type="radio"/> Data not collected	
<input type="radio"/> One year ago or more		
Are you currently fleeing?	<input type="radio"/> No	<input type="radio"/> Client doesn't know
	<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
		<input type="radio"/> Data not collected

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

<input type="radio"/> No	<input type="radio"/> Client doesn't know		
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer		
	<input type="radio"/> Data not collected		
IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY			
Income Source	Amount	Income Source	Amount
<input type="radio"/> Earned Income		<input type="radio"/> Temporary Assistance for Needy Families (TANF)	
<input type="radio"/> Unemployment Insurance		<input type="radio"/> General Assistance (GA)	
<input type="radio"/> Supplemental Security Income (SSI)		<input type="radio"/> Retirement income from Social Security	
<input type="radio"/> Social Security Disability Insurance (SSDI)		<input type="radio"/> Pension or retirement income from a former job	
<input type="radio"/> VA Service-Connected Disability Compensation		<input type="radio"/> Child support	
<input type="radio"/> VA Non-Service-Connected Disability Pension		<input type="radio"/> Alimony and other spousal support	
<input type="radio"/> Private disability insurance		<input type="radio"/> Other income source (<i>specify</i>):	
<input type="radio"/> Worker's Compensation			
Total Monthly Income for Individual:			

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

<input type="radio"/> No	<input type="radio"/> Client doesn't know
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
	<input type="radio"/> Data not collected
IF "YES" TO NON-CASH BENEFITS – INDICATE ALL SOURCES THAT APPLY	
<input type="radio"/> Supplemental Nutrition Assistance Program (SNAP)	<input type="radio"/> TANF Child Care Services
<input type="radio"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	<input type="radio"/> TANF Transportation Services
<input type="radio"/> Other (specify):	<input type="radio"/> Other TANF-funded services

COVERED BY HEALTH INSURANCE [*All Clients*]

<input type="radio"/> No	<input type="radio"/> Client doesn't know
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
	<input type="radio"/> Data not collected
IF "YES" TO HEALTH INSURANCE & REASONS NOT COVERED BY NON-CHOSEN SELECTION(S)	
<input type="radio"/> MEDICAID	<input type="radio"/> Applied; decision pending
	<input type="radio"/> Applied; client not eligible
	<input type="radio"/> Client did not apply
	<input type="radio"/> Insurance type N/A for this client
	<input type="radio"/> Client doesn't know
	<input type="radio"/> Client prefers not to answer
	<input type="radio"/> Data not collected
<input type="radio"/> MEDICARE	<input type="radio"/> Applied; decision pending
	<input type="radio"/> Applied; client not eligible
	<input type="radio"/> Client did not apply
	<input type="radio"/> Insurance type N/A for this client
	<input type="radio"/> Client doesn't know
	<input type="radio"/> Client prefers not to answer
	<input type="radio"/> Data not collected
<input type="radio"/> State Children's Health Insurance (SCHIP)	<input type="radio"/> Applied; decision pending
	<input type="radio"/> Applied; client not eligible
	<input type="radio"/> Client did not apply
	<input type="radio"/> Insurance type N/A for this client
	<input type="radio"/> Client doesn't know
	<input type="radio"/> Client prefers not to answer
	<input type="radio"/> Data not collected
<input type="radio"/> Veteran's Health Administration (VHA)	<input type="radio"/> Applied; decision pending
	<input type="radio"/> Applied; client not eligible
	<input type="radio"/> Client did not apply
	<input type="radio"/> Insurance type N/A for this client
	<input type="radio"/> Client doesn't know
	<input type="radio"/> Client prefers not to answer
	<input type="radio"/> 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

<input type="radio"/> No	<input type="radio"/> Client doesn't know
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
	<input type="radio"/> Data not collected
IF "NO" TO RECEIVING RYAN WHITE-FUNDED MEDICAL OR DENTAL ASSISTANCE – SPECIFY REASON	
<input type="radio"/> Applied; decision pending	<input type="radio"/> Client doesn't know
<input type="radio"/> Applied; client not eligible	<input type="radio"/> Client prefers not to answer
<input type="radio"/> Client did not apply	<input type="radio"/> Data not collected
<input type="radio"/> Insurance type N/A for this client	

T-cell (CD4) Count Available

<input type="radio"/> No	<input type="radio"/> Client doesn't know
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
	<input type="radio"/> Data not collected

T-cell Count (Integer between 0-1500): _____

How Was the Information Obtained?

<input type="radio"/> Medical Report
<input type="radio"/> Client report
<input type="radio"/> Other (specify)

Viral Load Information Available

<input type="radio"/> Not available	<input type="radio"/> Client doesn't know
<input type="radio"/> Available	<input type="radio"/> Client prefers not to answer
<input type="radio"/> Undetectable	<input type="radio"/> Data not collected

Count (Integer between 0-999999): _____

How Was the Information Obtained?

<input type="radio"/> Medical Report
<input type="radio"/> Client report
<input type="radio"/> Other (specify)

Has the participant been prescribed anti-retroviral drugs?

<input type="radio"/> No	<input type="radio"/> Client doesn't know
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
	<input type="radio"/> Data not collected

Signature of applicant stating all information is true and correct Date