

Agency Name: \_\_\_\_\_



## 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 |  |   | Day |  |   | Year |  |  |

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

|                                                                                                                   |                                                    |                                                    |
|-------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------|
| <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           |                                                    |
| <b>IF "YES" TO PHYSICAL DISABILITY – SPECIFY</b>                                                                  |                                                    |                                                    |
| 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** *[not required for SSVF]*

|                           |                                                    |
|---------------------------|----------------------------------------------------|
| <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** *[not required for SSVF]*

|                                                                                                                   |                                                    |                                                    |
|-------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------|
| <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           |                                                    |
| <b>IF "YES" TO CHRONIC HEALTH CONDITION – SPECIFY</b>                                                             |                                                    |                                                    |
| 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** *[not required for SSVF]*

|                           |                                                    |
|---------------------------|----------------------------------------------------|
| <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** *[not required for SSVF]*

|                                                                                                                   |                                                    |                                                    |
|-------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------|
| <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           |                                                    |
| <b>IF "YES" TO MENTAL HEALTH DISORDER – SPECIFY</b>                                                               |                                                    |                                                    |
| 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** *[not required for SSVF]*

|                                                                                                                   |                                                                              |
|-------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|
| <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                                                         |                                                                              |
| <b>IF "ALCOHOL USE DISORDER" "DRUG USE DISORDER" OR "BOTH ALCOHOL AND DRUG USE DISORDERS" – SPECIFY</b>           |                                                                              |
| 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                                     |
| <b>IF "YES" TO SURVIVOR OF DOMESTIC VIOLENCE – SPECIFY WHEN EXPERIENCE OCCURRED</b> |                                                                              |
| <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                                          |                                                                              |
| <b>Are you currently fleeing?</b>                                                   | <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           |                                                                      |               |
| <b>IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY</b> |                                                    |                                                                      |               |
| <b>Income Source</b>                                                        | <b>Amount</b>                                      | <b>Income Source</b>                                                 | <b>Amount</b> |
| <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                                 |                                                    |                                                                      |               |
| <b>Total Monthly Income for Individual:</b>                                 |                                                    |                                                                      |               |

**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           |
| <b>IF "YES" TO NON-CASH BENEFITS – INDICATE ALL SOURCES THAT APPLY</b>                              |                                                    |
| <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                      |
| <b>IF "YES" TO HEALTH INSURANCE – HEALTH INSURANCE COVERAGE DETAILS</b> |                                                               |
| <input type="radio"/> MEDICAID                                          | <input type="radio"/> Employer Provided Health Insurance      |
| <input type="radio"/> MEDICARE                                          | <input type="radio"/> Health Insurance Obtained Through COBRA |
| <input type="radio"/> State Children's Health Insurance (SCHIP)         | <input type="radio"/> Private Pay Health Insurance            |
| <input type="radio"/> Veteran's Health Administration (VHA)             | <input type="radio"/> State Health Insurance for Adults       |
| <input type="radio"/> Other (specify):                                  | <input type="radio"/> Indian Health Services Program          |

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

|                           |                                                    |
|---------------------------|----------------------------------------------------|
| <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           |

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

|                                                                                               |                           |
|-----------------------------------------------------------------------------------------------|---------------------------|
| <input type="radio"/> No                                                                      | <input type="radio"/> Yes |
| <b>IF "YES" TO PERMANENT HOUSING</b>                                                          |                           |
| <b>Housing Move-In Date:*</b>                                                                 | ____/____/____            |
| <i>*If client moved into permanent housing, make sure to update on the enrollment screen.</i> |                           |

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