

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



## 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			Day			Year		

**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 <b>enrollment screen</b>.</i>	

**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		
<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** *[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		
<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** *[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	
<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** *[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		
<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

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 Signature of applicant stating all information is true and correct

Date