

CLARITY HMIS: KC-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: _____

Please ask the questions in the order below assuring that the domestic violence questions are asked first. It is best practice to complete program enrollment with adult household members separately.

PROJECT STATUS DATE *[All Individuals/Client Households]*

		-			-				
Month			Day			Year			

DOMESTIC VIOLENCE VICTIM/SURVIVOR *[Head of Household and Adults]* Has the individual/client experienced a past or current relationship of any type that broke down or was unhealthy, controlling and/or abusive? (This includes domestic violence, dating violence, sexual assault, and stalking.)

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

IF "YES" TO DOMESTIC VIOLENCE

WHEN EXPERIENCE OCCURRED

<input type="radio"/>	Within the past three months	<input type="radio"/>	One year ago or more
<input type="radio"/>	Three to six months ago (excluding six months exactly)	<input type="radio"/>	Client doesn't know
		<input type="radio"/>	Client refused
<input type="radio"/>	Six months to one year ago (excluding one year exactly)	<input type="radio"/>	Data not collected

Are you currently fleeing?*

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

**If individual/client is currently fleeing or attempting to flee domestic violence please provide the Washington Coalition Against Domestic Violence Hotline at: 1-800-799-7233.*

IN PERMANENT HOUSING *[Permanent Housing Projects, for Heads of Households]*

<input type="radio"/>	No	<input type="radio"/>	Yes
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IF "YES" TO PERMANENT HOUSING

Housing Move-In Date: (See Note*)	<i>*If client moved into permanent housing, make sure to update on the enrollment screen.</i>
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CITY OF PERMANENT HOUSING LOCATION *[Rapid Re-Housing Projects, for Heads of Households]*

<input type="radio"/>	Unincorporated King County (includes any community not otherwise listed)	<input type="radio"/>	Medina
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○	Algona	○	Mercer Island
○	Auburn	○	Milton
○	Bear Creek/Sammamish (Unincorporated)	○	Newcastle
○	Beaux Arts	○	Normandy Park
○	Bellevue	○	North Highline (Unincorporated)
○	Black Diamond	○	North Bend
○	Bothell	○	Pacific
○	Burien	○	Redmond
○	Carnation	○	Renton
○	Clyde Hill	○	Sammamish
○	Covington	○	Sea Tac
○	Des Moines	○	Seattle
○	Duvall	○	Shoreline
○	East Federal Way (Unincorporated)	○	Skykomish
○	East Renton (Unincorporated)	○	Snoqualmie
○	Enumclaw	○	Snoqualmie Valley/Northeast King County (Unincorporated)
○	Fairwood (Unincorporated)	○	Southeast King County (Unincorporated)
○	Federal Way	○	Tukwila
○	Four Creeks/Tiger Mountain (Unincorporated)	○	Vashon/Maury Island
○	Hunts Point	○	West Hill (Unincorporated)
○	Issaquah	○	Woodinville
○	Kenmore	○	Yarrow Point
○	Kent	○	Washington State (outside of King County)
○	Kirkland	○	Outside of Washington State
○	Lake Forest Park	○	Client Doesn't Know
○	Maple Valley	○	Client Refused
○		Data Not Collected	

DISABLING CONDITION [All Individuals/Clients]

If individual/client is in need of resources, contact the following as appropriate:

For aging or disability support, call the Community Living Connections Line at: 206-962-8467/1-844-348-5464(Toll Free),

For crisis services: Crisis Connections at: 1-866-427-4747,

For mental health or substance use services: King County Behavioral Health Recovery Client Services Line: 1-800-790-8049,

For confidential peer support: Washington Warm Line 1-877-500-WARM(9276).

DOES THE INDIVIDUAL/CLIENT HAVE:
PHYSICAL DISABILITY and/or a PHYSICAL HEALTH CONDITION [All Individuals/Clients]

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

DEVELOPMENTAL DISABILITY [All Individuals/Client Households]

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

CHRONIC HEALTH CONDITION [All Individuals/Client Households]

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

MENTAL HEALTH PROBLEM [All Individuals/Client Households]

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

IF "YES" TO MENTAL 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 refused
		<input type="radio"/> Data not collected

SUBSTANCE ABUSE PROBLEM [All Individuals/Client Households]

<input type="radio"/> No	<input type="radio"/> Both alcohol and drug abuse
<input type="radio"/> Alcohol abuse	<input type="radio"/> Client doesn't know
	<input type="radio"/> Client refused
<input type="radio"/> Drug abuse	<input type="radio"/> Data not collected

IF "ALCOHOL ABUSE" "DRUG ABUSE" OR "BOTH ALCOHOL AND DRUG ABUSE" – 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 refused
			<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 refused
		<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 source	
<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 refused
		<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 Childcare 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 Individuals/Client Households]

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

IF "YES" TO HEALTH INSURANCE - HEALTH INSURANCE COVERAGE DETAILS

<input type="radio"/>	MEDICAID	<input type="radio"/>	Employer Provided Health Insurance
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<input type="radio"/>	MEDICARE	<input type="radio"/>	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 Administration (VA) Medical Services	<input type="radio"/>	State Health Insurance for Adults
<input type="radio"/>	Other (specify):	<input type="radio"/>	Indian Health Services Program

If applicable:

Signature of applicant stating all information is true and correct

Date