CLARITY HMIS: KC-EMPLOYMENT PROGRAM 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 DayYear

# **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.)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ○ | No | ○ | | | Client doesn’t know | | |
| ○ | Yes | ○ | | | Client refused | | |
| ○ | | | Data not collected | | |
| IF “YES” TO DOMESTIC VIOLENCE | | | | | | | |
| WHEN EXPERIENCE OCCURRED | | | | | | | |
| ○ | Within the past three months | | ○ | One year ago or more | | | |
| ○ | Three to six months ago (excluding six months exactly) | | ○ | Client doesn’t know | | | |
| ○ | Client refused | | | |
| ○ | Six months to one year ago (excluding one year exactly) | | ○ | Data not collected | | | |
| Are you currently fleeing?\* | | | ○ | No | | ○ | Client doesn’t know |
| ○ | Yes | | ○ | Client refused |
| ○ | 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.*

# **EMPLOYED**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ○ | No | | | | | ○ | Client doesn’t know |
| ○ | Yes | | | | | ○ | Client refused |
| ○ | Data not collected |
| **IF “YES” TO EMPLOYED** | | | | | | | |
| Employment Start Date | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ | | | | |
| Full or Part Time? | | | | ○ | Full Time | ○ | Seasonal/Sporadic (including day labor |
| ○ | Part Time |
| How many hours per week do you work? | | | \_\_\_\_\_\_\_\_\_\_ | | | | |
| Hourly Wage Earned | | | $\_\_\_\_\_\_\_\_\_ | | | | |
| Place of Employment | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Industry Sector | | | | | | | |
| ○ | | Natural Resources and Mining | | ○ | Professional and Business Services | | |
| ○ | | Construction | | ○ | Education and Health Services | | |
| ○ | | Manufacturing | | ○ | Leisure and Hospitality | | |
| ○ | | Trade, Transportation, and Utilities | | ○ | Client doesn’t know | | |
| ○ | | Information | | ○ | Client refused | | |
| ○ | | Financial Activities | | ○ | Data not collected | | |

# **PARTICIPATING IN TRAINING OR APPRENTICESHIP?**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ○ | No | | ○ | | Yes | | |
| **IF “YES” TO PARTICIPATING IN TRAINING OR APPRENTICESHIP** | | | | | | | |
| Training or Apprenticeship Start Date | | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ | | | |
| Training or Apprenticeship Type | | | | | | | |
| ○ | | Apprenticeship – paid through program | | | | ○ | Job related certification training - paid through employer |
| ○ | | Apprenticeship – paid through employer | | | | ○ | Other Training |
| ○ | | Apprenticeship - unpaid | | | | ○ | Client doesn’t know |
| ○ | | Job related certification training - paid through program | | | | ○ | Client refused |
| ○ | | Job related certification training – no cost | | | | ○ | Data not collected |

# **TRAINING OR APPRENTICESHIP COMPLETED?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ○ | No | ○ | | Yes |
| **IF “YES” TO TRAINING OR APPRENTICESHIP COMPLETED** | | | | |
| Training or Apprenticeship Completion Date | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ | |

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 INDIVDUAL/CLIENT HAVE:

A PHYSICAL DISABILITY ​ and/or PHYSICAL HEALTH CONDITION ​*[All Individuals/Clients]*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ○ | No | | | ○ | Client doesn’t know |
| ○ | Yes | | | ○ | Client refused |
| ○ | 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 refused |
| ○ | Data not collected |

A DEVELOPMENTAL DISABILITY ​*[All Individuals/Clients]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client refused |
| ○ | Data not collected |

A CHRONIC HEALTH CONDITION *[All Individuals/Clients]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client refused |
| ○ | 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 refused |
| ○ | Data not collected |

A MENTAL HEALTH CONDITION ​*[All Individuals/Clients]*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ○ | No | | | ○ | Client doesn’t know |
| ○ | Yes | | | ○ | Client refused |
| ○ | 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? | | ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client refused |
| ○ | Data not collected |

A SUBSTANCE ABUSE ISSUE ​*[All Individuals/Clients]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Both alcohol and drug abuse |
| ○ | Alcohol abuse | ○ | Client doesn’t know |
| ○ | Client refused |
| ○ | Drug abuse | ○ | 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? | ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client refused |
| ○ | Data not collected |

# 

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

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client refused |
| ○ | 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 source |  |
| ○ | Worker’s Compensation |  |  | | |
| Total Monthly Income for Individual: | |  | | | |

# **RECEIVING NON­CASH BENEFITS**​ ​[Head of Household and Adults]

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ○ | No | | | ○ | Client doesn’t know |
| ○ | Yes | | | ○ | Client refused |
| ○ | Data not collected |
| IF “YES” TO NON­CASH BENEFITS – INDICATE ALL SOURCES THAT APPLY | | | | | |
| ○ | Supplemental Nutrition Assistance Program (SNAP) | ○ | TANF Childcare 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 Individuals/Clients]*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ○ | No | | | ○ | Client doesn’t know |
| ○ | Yes | | | ○ | Client refused |
| ○ | Data not collected |
| IF “YES” TO HEALTH INSURANCE ­ HEALTH INSURANCE COVERAGE DETAILS | | | | | |
| ○ | MEDICAID | ○ | Employer Provided Health Insurance | | |
| ○ | MEDICARE | ○ | Insurance Obtained through COBRA | | |
| ○ | State Children’s Health Insurance (SCHIP) | ○ | Private Pay Health Insurance | | |
| ○ | Veteran’s Administration (VA) Medical Services | ○ | State Health Insurance for Adults | | |
| ○ | Other (specify): | ○ | Indian Health Services Program | | |

Signature of applicant stating all information is true and correct Date