

CLARITY HMIS: KC- HHS-RHY-CoC PROGRAM STATUS UPDATE 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			

CLIENT LOCATION *[only if multiple CoC's]* _____

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

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

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.*

RHY BCP STATUS *[If not collected at Entry]*

Date of status determination		___/___/___	
FYSB “Youth Eligible for RHY Services”			
<input type="radio"/>	No	<input type="radio"/>	Yes
If ‘No’ for “Youth Eligible for RHY Services” - Reason services are not funded by BCP grant			
<input type="radio"/>	Out of age range	<input type="radio"/>	Ward of the criminal justice system – immediate reunification
<input type="radio"/>	Ward of the State – Immediate Reunification	<input type="radio"/>	Other
Runaway Youth? <i>[If ‘Yes’ to ‘Youth Eligible for RHY Services’]</i>		<input type="radio"/>	Client doesn’t know
<input type="radio"/>	No	<input type="radio"/>	Client Refused
<input type="radio"/>	Yes	<input type="radio"/>	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/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

CHRONIC 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 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 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 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 ISSUE *[All Individuals/Clients]*

<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 Income 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 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 HEALTH INSURANCE - HEALTH INSURANCE COVERAGE DETAILS

<input type="radio"/>	MEDICAID	<input type="radio"/>	Employer Provided Health Insurance
<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

SPECIFIC YOUTH INFORMATION

PREGNANCY STATUS *[Female Adults and Head of Households]*

<input type="radio"/>	No	<input type="radio"/>	Client doesn't know
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<input type="radio"/>	Yes	<input type="radio"/>	Client refused
		<input type="radio"/>	Data not collected
IF "YES" for Pregnancy Status			
Due Date		____/____/____	

If applicable:

Signature of applicant stating all information is true and correct

Date