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



# San Francisco ONE System: 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.

	Please complete a separate form for each household member.													
CL	CLIENT NAME OR IDENTIFIER:													
	<del></del>													
	PROJECT STATUS DATE [All Clients]													
				-			-							
		Мо	nth			Day	•			Y	ear			
IN I	PERM	ANE	NT H	IOUS	ING [/	Perm	anen	t Hous	sing F	Project	s, for	Heads or	f Hou	seholds]
0	No						C	> Ye	s					
IF "	YES"	TO F	PERM	IANE	NT H	OUS	NG							
Ηοι	ısing l	Move	e-in [	Date					/_	/_				
DIS	ABLII	NG C	ONE	OITIO	<b>N</b> [A]	Clien	ts]							
0	No												0	Client doesn't know
	V												0	Client refused
0	Yes												0	Data not collected
PH	YSICA	\L DI	SAB	ILITY	' [AII C	Client	s]							
0	No												0	Client doesn't know
0	Yes												0	Client refused
O	163												0	Data not collected
IF '	'YES"	ТО	PHYS	<u>SICAI</u>	L DIS	ABIL	ITY –	SPE	CIFY		T	1	T	
Evr	ected	to b	o of l	ona c	ontini	ıod a	nd in	dofinit	o dur	ation	0	No	0	Client doesn't know
	d subst			_							0	Yes	0	Client refused
			,			,				, .	Ŭ	100	0	Data not collected
DE	DEVELOPMENTAL DISABILITY [All Clients]													
0	No												0	Client doesn't know
0	<ul> <li>Yes</li> <li>Client refused</li> </ul>							Client refused						
o Data not collected								Data not collected						
IF "YES" TO DEVELOPMENTAL DISABILITY – SPECIFY														
Ev.	ootod	to o	ihete	ntiall	v imna	vir ob	ilitv, ta	Livo			0	No	0	Client doesn't know
	pected epend			ırıuanı	у шира	ııı ab	mty to	iive				Yes	0	Client refused
independently?					0	Data not collected								



**CHRONIC HEALTH CONDITION** [All Clients]

0	No	0	Client doesn't know				
. Vas				0	Client refused		
O	· Yes			0	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  Yes			0	Client doesn't know		
							0
and substantially impairs ability to live independently? o Yes			168	0	Data not collected		

**HIV-AIDS** [All Clients]

0	No	0	Client doesn't know					
	Voc				Client refused			
O	· Yes			0	Data not collected			
IF '	IF "YES" TO HIV-AIDS – SPECIFY							
Expected to substantially impair ability to live independently?		0	No	0	Client doesn't know			
		_	Vaa	0	Client refused			
iiiu	ependently?		Yes	0	Data not collected			

**MENTAL HEALTH PROBLEM** [All Clients]

o No					Client doesn't know			
	Voc	0	Client refused					
0	Yes	0	Data not collected					
IF '	IF "YES" TO MENTAL HEALTH CONDITION – SPECIFY							
	_				Client doesn't know			
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?    Output  Description:  Output  Descrip				Client refused				
and substantially impairs ability to live independently? Yes			0	Data not collected				

**SUBSTANCE ABUSE PROBLEM** [All Clients]

0	No	0	Both alcohol and drug abuse					
	Alcohol abuse		Client doesn't know					
0			Client ref	Client refused				
0	Drug abuse			Data not collected				
	IF "ALCOHOL ABUSE" "DRUG ABUSE" OR "BOTH ALCOHOL AND DRUG ABUSE" – SPECIFY							
_				0	Client doesn't know			
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		0	Yes	0	Client refused			
and	substantially impairs ability to live independently:		168	0	Data not collected			



## **DOMESTIC VIOLENCE VICTIM/SURVIVOR** [Head of Household and Adults]

0	No	0	Client doesn't know					
	Yes	0	Client refused					
0	ies	0	Data not	colle	cted			
IF '	YES" TO DOMESTIC VIOLENCE							
WH	IEN EXPERIENCE OCCURRED							
0	Within the past three months	0	One year ago or more					
	Three to six months ago (excluding six months	0	Client doesn't know					
0	exactly)	0	Client refused					
0	Six months to one year ago (excluding one year exactly)	0	Data not collected					
		0	No	0	Client doesn't know			
Are	Are you currently fleeing?		Vaa	0	Client refused			
		0	Yes	0	Data not collected			

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

0	No				0	Client does	n't know			
	Yes				0	Client refus	ed			
0					0	Data not co	llected			
IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY										
	Income Source Amount Income Source Amo									
0	Alimony and other spousal support		0	Child support						
0	Pension or retirement income from former job		0	Earned In						
0	Retirement Income from Social Security		0	CAAP						
0	Social Security Disability Insurance (SSDI)		0	Private disability insurance						
0	Supplemental Security Income (SSI)		0	Unemploy						
0	CalWORKs		0	Worker's Compensation						
0	VA Service Connected Disability Compensation		0	Other source						
0	VA NonService Connected Disability Pension		Othe	r (specify):						
Tota	l monthly amount:									



#### **RECEIVING NON-CASH BENEFITS** [Head of Household and Adults]

0	No No				Client doesn't know		
	Maa			0	Client refused		
0	Yes	0	Data not collected				
IF "YES" TO NON-CASH BENEFITS – INDICATE ALL SOURCES THAT APPLY							
0	CalFresh	0	CalWORKs Childcare Services				
0	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	0	CalWORKs Transportation Services				
0	Other (specify):	0	CalWORKs TANF-funded services				

#### **COVERED BY HEALTH INSURANCE** [All Clients]

0	No				Client doesn't know		
	- V			0	Client refused		
0	res	Yes					
IF "	IF "YES" TO HEALTH INSURANCE - HEALTH INSURANCE COVERAGE DETAILS						
0	MANI-C31			oloyer Provided Health rance			
0	MEDICARE	0	Insurance Obtained through COBRA				
0	State Children's Health Insurance (SCHIP)	0	Private Pay Health Insurance				
0	Veteran's Administration (VA) Medical Services				Insurance for Adults		
0	Other (specify):				Indian Health Services Program		