Agency Name: _____

CLARITY
HUMAN SERVICES

San Francisco ONE System: HUD-HOPWA PROJECT 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**

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

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

○	No	○	Yes

IF "YES" TO PERMANENT HOUSING

Housing Move-in Date	____/____/_____

DISABLING CONDITION *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected

PHYSICAL DISABILITY *[All 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

DEVELOPMENTAL DISABILITY *[All Clients]*

○	No		○	Client doesn't know
○	Yes		○	Client refused
			○	Data not collected

IF "YES" TO DEVELOPMENTAL DISABILITY – SPECIFY				
Expected to substantially impair ability to live independently?	○	No	○	Client doesn't know
	○	Yes	○	Client refused
			○	Data not collected

CHRONIC HEALTH CONDITION *[All 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

HIV-AIDS *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected

IF "YES" TO HIV-AIDS – SPECIFY

Expected to substantially impair ability to live independently?	○	No	○	Client doesn't know
	○	Yes	○	Client refused
			○	Data not collected

MENTAL HEALTH PROBLEM *[All 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

SUBSTANCE ABUSE PROBLEM *[All 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

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

○	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

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
○	Alimony and other spousal support		○	Child support	
○	Pension or retirement income from former job		○	Earned Income	
○	Retirement Income from Social Security		○	CAAP	
○	Social Security Disability Insurance (SSDI)		○	Private disability insurance	
○	Supplemental Security Income (SSI)		○	Unemployment Insurance	
○	CalWORKs		○	Worker's Compensation	
○	VA Service Connected Disability Compensation		○	Other source	
○	VA Non--Service Connected Disability Pension		Other (specify):	
Total monthly amount:					

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

○	No		○	Client doesn't know
○	Yes		○	Client refused
			○	Data not collected

IF "YES" TO NON-CASH BENEFITS – INDICATE ALL SOURCES THAT APPLY				
○	CalFresh	○	CalWORKs Childcare Services	
○	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	○	CalWORKs Transportation Services	
○	Other (specify):	○	Other CalWORKs-funded services	

COVERED BY HEALTH INSURANCE *[All Clients]*

○	No		○	Client doesn't know
○	Yes		○	Client refused
			○	Data not collected

IF "YES" TO HEALTH INSURANCE & REASONS NOT COVERED BY NON-CHOSEN SELECTION(S)

○	Medi-Cal	○	Applied; Decision Pending
		○	Applied; Client Not Eligible
		○	Client Did Not Apply
		○	Insurance Type N/A for this Client
		○	Client Doesn't Know
		○	Client Refused
		○	Data Not Collected
○	MEDICARE	○	Applied; Decision Pending
		○	Applied; Client Not Eligible
		○	Client Did Not Apply
		○	Insurance Type N/A for this Client
		○	Client Doesn't Know
		○	Client Refused
		○	Data Not Collected

(Continued on next page)

IF "YES" TO HEALTH INSURANCE & REASONS NOT COVERED BY NON-CHOSEN SELECTION(S)

○	State Children's Health Insurance (SCHIP)	○	Applied; Decision Pending
		○	Applied; Client Not Eligible
		○	Client Did Not Apply
		○	Insurance Type N/A for this Client
		○	Client Doesn't Know
		○	Client Refused
		○	Data Not Collected
○	Veteran's Administration (VA) Medical Services	○	Applied; Decision Pending
		○	Applied; Client Not Eligible
		○	Client Did Not Apply
		○	Insurance Type N/A for this Client
		○	Client Doesn't Know
		○	Client Refused
		○	Data Not Collected
○	Employer Provided Health Insurance	○	Applied; Decision Pending
		○	Applied; Client Not Eligible
		○	Client Did Not Apply
		○	Insurance Type N/A for this Client
		○	Client Doesn't Know
		○	Client Refused
		○	Data Not Collected
○	Health Insurance Obtained through COBRA	○	Applied; Decision Pending
		○	Applied; Client Not Eligible
		○	Client Did Not Apply
		○	Insurance Type N/A for this Client
		○	Client Doesn't Know
		○	Client Refused
		○	Data Not Collected
○	Private Pay Health Insurance	○	Applied; Decision Pending
		○	Applied; Client Not Eligible
		○	Client Did Not Apply
		○	Insurance Type N/A for this Client
		○	Client Doesn't Know
		○	Client Refused
		○	Data Not Collected

IF "YES" TO HEALTH INSURANCE & REASONS NOT COVERED BY NON-CHOSEN SELECTION(S)

○	State Health Insurance for Adults	○	Applied; Decision Pending
		○	Applied; Client Not Eligible
		○	Client Did Not Apply
		○	Insurance Type N/A for this Client
		○	Client Doesn't Know
		○	Client Refused
		○	Data Not Collected
○	Indian Health Services Program	○	Applied; Decision Pending
		○	Applied; Client Not Eligible
		○	Client Did Not Apply
		○	Insurance Type N/A for this Client
		○	Client Doesn't Know
		○	Client Refused
		○	Data Not Collected
○	Other Health Insurance **(specify)**		

IF "YES" TO HIV-AIDS:
Receiving Public HIV/AIDS Medical Assistance?

○	Receiving Public HIV/AIDS Medical Assistance	○	Applied; Decision Pending
		○	Applied; Client Not Eligible
		○	Client Did Not Apply
		○	Insurance Type N/A for this Client
		○	Client Doesn't Know
		○	Client Refused
		○	Data Not Collected

Receiving AIDS Drug Assistance Program (ADAP)?

○	Receiving AIDS Drug Assistance Program (ADAP)	○	Applied; Decision Pending
		○	Applied; Client Not Eligible
		○	Client Did Not Apply
		○	Insurance Type N/A for this Client
		○	Client Doesn't Know
		○	Client Refused
		○	Data Not Collected

T-cell (CD4) Count Available

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected

T-cell Count (Integer between 0-1500): _____

How Was the Information Obtained?

○	Medical Report
○	Client Reported
○	Other (specify)

Viral Load Information Available

○	Available	○	Not Available
○	Undetectable	○	Client Doesn't Know
○	Client Refused	○	Data Not Collected

Count (Integer between 0-999999): _____

How Was the Information Obtained?

○	Medical Report
○	Client Reported
○	Other (specify)

_____

Signature of applicant stating all information is true and correct   Date