Agency Name: _____

CLARITY HMIS: SCC UPLIFT 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

UPLIFT: IS THE CLIENT HOMELESS OR SERIOUSLY AT RISK OF LOSING THEIR HOUSING DUE TO LACK OF TRANSPORTATION? *[All Clients]*

○	Yes

UPLIFT: IS THE CLIENT HOMELESS? *[All Clients]*

○	No	○	Yes

UPLIFT: IS THE CLIENT CURRENTLY RECEIVING CASE MANAGEMENT FROM YOUR AGENCY? *[All Clients]*

○	Yes

UPLIFT: WHAT TYPE OF TRANSIT PASS ARE YOU REQUESTING? *[All Clients]*

○	Badge only	○	Badge and Sticker
○	Sticker		

UPLIFT: WHAT TIME PERIOD IS THE PASS FOR? *[All Clients]*

○	Jan-Mar	○	Jul-Sep
○	Apr-Jun	○	Oct-Dec

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

CLARITY HUMAN SERVICES

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		○	General Assistance (GA)	
○	Social Security Disability Insurance (SSDI)		○	Private disability insurance	
○	Supplemental Security Income (SSI)		○	Unemployment Insurance	
○	TANF (Temporary Assist for Needy Families)		○	Worker's Compensation	
○	VA Service Connected Disability Compensation		○	Other source	
○	VA Non-Service Connected Disability Pension		Other (specify):		
Total monthly amount:					

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 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