CLARITY HMIS: KC-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.

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.

PROGRAM STATUS DATE *[All Individuals/Client Households]*

Month Day Year

SURVIVOR OF DOMESTIC VIOLENCE *[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 prefers not to answer
		○	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 prefers not to answer
○	Six months to one year ago (excluding one year exactly)	○	Data not collected

Are you currently fleeing?*	○	No	○	Client doesn't know
	○	Yes	○	Client prefers not to answer
			○	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: 877-737-0242 or 206-737-0242**.**

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

○	No	○	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**.*	

CITY OF PERMANENT HOUSING LOCATION *[Rapid Re-Housing Projects, for Heads of Households]*

○	Unincorporated King County (includes any community not otherwise listed)	○	Medina
○	Algona	○	Mercer Island
○	Auburn	○	Milton
○	Bear Creek/Sammamish (Unincorporated)	○	Newcastle
○	Beaux Arts	○	Normandy Park
○	Bellevue	○	North Highline (Unincorporated)
○	Black Diamond	○	North Bend
○	Bothell	○	Pacific
○	Burien	○	Redmond
○	Carnation	○	Renton
○	Clyde Hill	○	Sammamish
○	Covington	○	Sea Tac
○	Des Moines	○	Seattle
○	Duvall	○	Shoreline
○	East Federal Way (Unincorporated)	○	Skykomish
○	East Renton (Unincorporated)	○	Snoqualmie
○	Enumclaw	○	Snoqualmie Valley/Northeast King County (Unincorporated)
○	Fairwood (Unincorporated)	○	Southeast King County (Unincorporated)
○	Federal Way	○	Tukwila
○	Four Creeks/Tiger Mountain (Unincorporated)	○	Vashon/Maury Island
○	Hunts Point	○	West Hill (Unincorporated)
○	Issaquah	○	Woodinville
○	Kenmore	○	Yarrow Point
○	Kent	○	Washington State (outside of King County)
○	Kirkland	○	Outside of Washington State
○	Lake Forest Park	○	Client Doesn't Know
○	Maple Valley	○	Client prefers not to answer
		○	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]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	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 prefers not to answer
			○	Data not collected

DEVELOPMENTAL DISABILITY *[All Individuals/Client Households]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected

CHRONIC HEALTH CONDITION *[All Individuals/Client Households]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	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 prefers not to answer
			○	Data not collected

MENTAL HEALTH PROBLEM *[All Individuals/Client Households]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	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 prefers not to answer
			○	Data not collected

SUBSTANCE ABUSE PROBLEM *[All Individuals/Client Households]*

○	No	○	Both alcohol and drug use disorder
○	Alcohol use disorder	○	Client doesn't know
		○	Client prefers not to answer
○	Drug use disorder	○	Data not collected

IF "ALCOHOL USE DISORDER" "DRUG USE DISORDER" OR "BOTH ALCOHOL AND DRUG USE DISORDER" – SPECIFY				
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	○	No	○	Client doesn't know
	○	Yes	○	Client prefers not to answer
			○	Data not collected

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

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	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 NON CASH BENEFITS *[Head of Household and Adults]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected

IF "YES" TO NONCASH BENEFITS – INDICATE ALL SOURCES THAT APPLY			
○	Supplemental Nutrition Assistance Program (SNAP)	○	TANF Child Care 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/Client Households]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	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
○	Veterans Health Administration (VHA)	○	State Health Insurance for Adults
○	Other (specify):	○	Indian Health Services Program

If applicable:

Signature of applicant stating all information is true and correct **Date**