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: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

PROGRAM STATUS DATE​ *​[All Clients]*

|   |  |  *­*  |  |  |  *­*  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |

 Month DayYear

ENROLLMENT CoC*[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: (See *Note\**) | *\*If client moved into permanent housing, make sure to update on the* ***enrollment screen****.* |

# **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

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/Clients]*

| ○ | No  | ○ | Client doesn’t know  |
| --- | --- | --- | --- |
| ○ | Yes  | ○ | Client prefers not to answer  |
| ○ | Data not collected  |

CHRONIC HEALTH CONDITION ​​*[All Individuals/Clients]*

| ○ | 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 CONDITION ​​*[All Individuals/Clients]*

| ○ | 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 ISSUE ​*[All Individuals/Clients]*

| ○ | 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  |

#

# **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 Income 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 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 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 |

SPECIFIC YOUTH INFORMATION

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

| ○ | No | ○ | Client doesn’t know  |
| --- | --- | --- | --- |
| ○ | Yes | ○ | Client prefers not to answer  |
| ○ | Data not collected  |
| IF “YES” for Pregnancy Status |
| Due Date | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_\_  |

*If applicable:*



Signature of applicant stating all information is true and correct Date