Agency Name: _____

CLARITY HMIS: HHS-RHY 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:_____

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

RHY BCP STATUS [*If not collected at Entry]*

Date of status determination		____/____/_____	
FYSB "Youth Eligible for RHY Services"			
○	**No**	○	**Yes**
If 'No' for "Youth Eligible for RHY Services" - Reason services are not funded by BCP grant			
○	Out of age range	○	Ward of the criminal justice system – immediate reunification
○	Ward of the State – Immediate Reunification	○	Other
Runaway Youth? *[If 'Yes' to 'Youth Eligible for RHY Services']*		○	Client doesn't know
○	No	○	Client Refused
○	Yes	○	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

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

MENTAL HEALTH DISORDER *[All Clients]*

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

IF "YES" TO MENTAL HEALTH 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 refused
			○	Data not collected

SUBSTANCE USE DISORDER *[All Clients]*

○	No	○	Both alcohol and drug use disorders
○	Alcohol use disorder	○	Client doesn't know
		○	Client refused
○	Drug use disorder	○	Data not collected

IF "ALCOHOL USE DISORDER" "DRUG USE DISORDER" OR "BOTH ALCOHOL AND DRUG USE DISORDERS" – 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

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**
○	Earned Income		○	TANF (Temporary Assist for Needy Families)	
○	Unemployment Insurance		○	General Assistance (GA)	
○	Supplemental Security Income (SSI)		○	Retirement Income from Social Security	
○	Social Security Disability Insurance (SSDI)		○	Pension or retirement income from 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 *(specify):*	
○	Worker's Compensation				
Total monthly income for Individual:					

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			
○	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
○	Veterans Administration (VA) Medical Services	○	State Health Insurance for Adults
○	Other (specify):	○	Indian Health Services Program

RHY SPECIFIC YOUTH INFORMATION

PREGNANCY STATUS *[Adults and Head of Households]*

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected
IF "YES" for Pregnancy Status			
Due Date	____/____/_____		

_____

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