Agency Name: _____

CLARITY HMIS: [HPS] 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: _____

PROJECT STATUS DATE *[All Clients]*

		-			-				
Month			Day			Year			

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**.*	

PHYSICAL DISABILITY *[All 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 Clients]*

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

CHRONIC HEALTH CONDITION *[All 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


CLARITY
HUMAN SERVICES

HIV-AIDS *[All Clients]*

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

MENTAL HEALTH DISORDER *[All Clients]*

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

SUBSTANCE USE DISORDER *[All 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

SURVIVOR OF DOMESTIC VIOLENCE *[Head of Household and Adults]*

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

IF "YES" TO SURVIVOR OF 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


CLARITY
HUMAN SERVICES

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 *(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 prefers not to answer
		○	Data not collected

IF "YES" TO NON-CASH 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 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

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