

Agency Name: _____



CLARITY HMIS: VA SERVICES STATUS FORM (Including HUD VASH, SSVF, GPD)

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]* _____

PHYSICAL DISABILITY *[not required for SSVF]*

<input type="radio"/> No		<input type="radio"/>	Client doesn't know
<input type="radio"/> Yes		<input type="radio"/>	Client refused
		<input type="radio"/>	Data not collected
IF "YES" TO PHYSICAL DISABILITY – SPECIFY			
Expected to be of long-continued and indefinite duration?		<input type="radio"/>	No
		<input type="radio"/>	Yes
		<input type="radio"/>	Client doesn't know
		<input type="radio"/>	Client refused
		<input type="radio"/>	Data not collected

DEVELOPMENTAL DISABILITY *[not required for SSVF]*

<input type="radio"/> No		<input type="radio"/>	Client doesn't know
<input type="radio"/> Yes		<input type="radio"/>	Client refused
		<input type="radio"/>	Data not collected

CHRONIC HEALTH CONDITION *[not required for SSVF]*

<input type="radio"/> No		<input type="radio"/>	Client doesn't know
<input type="radio"/> Yes		<input type="radio"/>	Client refused
		<input type="radio"/>	Data not collected
IF "YES" TO CHRONIC HEALTH CONDITION – SPECIFY			
Expected to be of long-continued and indefinite duration?		<input type="radio"/>	No
		<input type="radio"/>	Yes
		<input type="radio"/>	Client doesn't know
		<input type="radio"/>	Client refused
		<input type="radio"/>	Data not collected

HIV-AIDS *[not required for SSVF]*

<input type="radio"/> No		<input type="radio"/>	Client doesn't know
<input type="radio"/> Yes		<input type="radio"/>	Client refused
		<input type="radio"/>	Data not collected

MENTAL HEALTH DISORDER [not required for SSVF]

<input type="radio"/> No	<input type="radio"/> Client doesn't know	
<input type="radio"/> Yes	<input type="radio"/> Client refused	
	<input type="radio"/> Data not collected	
IF "YES" TO MENTAL HEALTH DISORDER- SPECIFY		
Expected to be of long-continued and indefinite duration?	<input type="radio"/> No	<input type="radio"/> Client doesn't know
	<input type="radio"/> Yes	<input type="radio"/> Client refused
		<input type="radio"/> Data not collected

SUBSTANCE USE DISORDER [not required for SSVF]

<input type="radio"/> No	<input type="radio"/> Both alcohol and drug use disorders	
<input type="radio"/> Alcohol use disorder	<input type="radio"/> Client doesn't know	
	<input type="radio"/> Client refused	
<input type="radio"/> Drug use disorder	<input type="radio"/> 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?	<input type="radio"/> No	<input type="radio"/> Client doesn't know
	<input type="radio"/> Yes	<input type="radio"/> Client refused
		<input type="radio"/> Data not collected

DOMESTIC VIOLENCE VICTIM/ SURVIVOR [Heads of Household & Adults]

<input type="radio"/> No	<input type="radio"/> Client doesn't know	
<input type="radio"/> Yes	<input type="radio"/> Client refused	
	<input type="radio"/> Data not collected	
IF "YES" TO DOMESTIC VIOLENCE		
LAST OCCURRENCE _____ / ____ / _____		
<input type="radio"/> Within the past three months	<input type="radio"/> One year ago or more	
<input type="radio"/> Three to six months ago (excluding six months exactly)	<input type="radio"/> Client doesn't know	
	<input type="radio"/> Client refused	
<input type="radio"/> Six months to one year ago (excluding one year exactly)	<input type="radio"/> Data not collected	
Are you currently fleeing?	<input type="radio"/> No	<input type="radio"/> Client doesn't know
	<input type="radio"/> Yes	<input type="radio"/> Client refused
		<input type="radio"/> Data not collected

<input type="radio"/> Yes	<input type="radio"/> Client refused
	<input type="radio"/> Data not collected
IF "YES" TO HEALTH INSURANCE - HEALTH INSURANCE COVERAGE DETAILS	
<input type="radio"/> MEDICAID	<input type="radio"/> Employer Provided Health Insurance
<input type="radio"/> MEDICARE	<input type="radio"/> Insurance Obtained through COBRA
<input type="radio"/> State Children's Health Insurance (SCHIP)	<input type="radio"/> Private Pay Health Insurance
<input type="radio"/> Veterans Administration (VA) Medical Services	<input type="radio"/> State Health Insurance for Adults
<input type="radio"/> Other (specify)	<input type="radio"/> Indian Health Services Program

CONNECTION WITH SOAR [*Heads of Households and Adults, For SSVF and VA: Grant per Diem – Case Management/Housing Retention*]

<input type="radio"/> No	<input type="radio"/> Client doesn't know
<input type="radio"/> Yes	<input type="radio"/> Client refused
	<input type="radio"/> Data not collected

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

<input type="radio"/> No	<input type="radio"/> Yes
IF "YES" TO PERMANENT HOUSING	
Housing Move-in Date (see note*)	<i>*If client moved into permanent housing, make sure to update on the enrollment screen.</i>

Signature of applicant stating all information is true and correct Date