**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 DayYear

**PHYSICAL DISABILITY ​*[not required for SSVF]***

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

**DEVELOPMENTAL DISABILITY** ​*[****not required for SSVF****]*

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

**CHRONIC HEALTH CONDITION** ​***[not required for SSVF]***

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

**HIV-AIDS** ​*[****not required for SSVF****]*

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

**MENTAL HEALTH DISORDER** ​***[not required for SSVF]***

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

**SUBSTANCE USE DISORDER ​*[not required for SSVF]***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ○ | No | ○ | Both alcohol and drug use disorders | | |
| ○ | 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 DISORDERS” – SPECIFY** | | | | | |
| Expected to be of long-continued and indefinite duration? | | ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
| ○ | Data not collected |

# 

# **SURVIVOR OF DOMESTIC VIOLENCE** [Heads of Household & Adults]

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ○ | No | ○ | | | Client doesn’t know | | |
| ○ | Yes | ○ | | | Client prefers not to answer | | |
| ○ | | | Data not collected | | |
| **IF “YES” TO SURVIVOR OF DOMESTIC VIOLENCE** | | | | | | | |
| **LAST OCCURRENCE** \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| ○ | 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 |

# **MONTHLY INCOME AND SOURCES** ​[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 | |  | ○ | 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 | | |  |
| ○ | Worker’s Compensation | |  | *(specify):* | | |
| **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 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 | | |

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

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

# **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.* |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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