

Agency Name: _____



CLARITY HMIS: 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]*

<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>

PHYSICAL DISABILITY *[All Clients]*

<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 and substantially impairs ability to live independently?	<input type="radio"/>	No	<input type="radio"/>	Client doesn't know
	<input type="radio"/>	Yes	<input type="radio"/>	Client refused
	<input type="radio"/>		<input type="radio"/>	Data not collected

DEVELOPMENTAL DISABILITY *[All Clients]*

<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 *[All Clients]*

<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 and substantially impairs ability to live independently?	<input type="radio"/>	No	<input type="radio"/>	Client doesn't know
	<input type="radio"/>	Yes	<input type="radio"/>	Client refused
	<input type="radio"/>		<input type="radio"/>	Data not collected

HIV-AIDS [All Clients]

<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 [All Clients]

<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 and substantially impairs ability to live independently?	<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 [All Clients]

<input type="radio"/> No	<input type="radio"/> Both alcohol and drug use disorder
<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 DISORDER" - SPECIFY

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	<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 [Head of Household and 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
WHEN EXPERIENCE OCCURRED

<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?

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

INCOME FROM ANY SOURCE [Head of Household and 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 INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY

Income Source		Amount	Income Source		Amount
<input type="radio"/>	Earned Income		<input type="radio"/>	Temporary Assistance for Needy Families (TANF)	
<input type="radio"/>	Unemployment Insurance		<input type="radio"/>	General Assistance (GA)	
<input type="radio"/>	Supplemental Security Income (SSI)		<input type="radio"/>	Retirement Income from Social Security	
<input type="radio"/>	Social Security Disability Insurance (SSDI)		<input type="radio"/>	Pension or Retirement Income from a Former Job	
<input type="radio"/>	VA Service-Connected Disability Compensation		<input type="radio"/>	Child Support	
<input type="radio"/>	VA Non-Service-Connected Disability Pension		<input type="radio"/>	Alimony and Other Spousal Support	
<input type="radio"/>	Private Disability Insurance		<input type="radio"/>	Other income source (specify):	
<input type="radio"/>	Worker's Compensation				
Total Monthly Income for Individual:					

RECEIVING NON CASH BENEFITS [Head of Household and 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 NONCASH BENEFITS – INDICATE ALL SOURCES THAT APPLY

<input type="radio"/>	Supplemental Nutrition Assistance Program (SNAP)	<input type="radio"/>	TANF Child Care Services
<input type="radio"/>	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	<input type="radio"/>	TANF Transportation Services
<input type="radio"/>	Other (specify):	<input type="radio"/>	Other TANF-funded services

COVERED BY HEALTH INSURANCE [All Clients]

<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 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

CLIENT PERCEIVES THEIR LIFE HAS VALUE AND WORTH *[Head of Household]*

<input type="radio"/>	Strongly disagree	<input type="radio"/>	Strongly agree
<input type="radio"/>	Somewhat disagree	<input type="radio"/>	Client doesn't know
<input type="radio"/>	Neither agree nor disagree	<input type="radio"/>	Client refused
<input type="radio"/>	Somewhat agree	<input type="radio"/>	Data not collected

CLIENT PERCEIVES THEY HAVE SUPPORT FROM OTHERS WHO WILL LISTEN TO PROBLEMS *[Head of Household]*

<input type="radio"/>	Strongly disagree	<input type="radio"/>	Strongly agree
<input type="radio"/>	Somewhat disagree	<input type="radio"/>	Client doesn't know
<input type="radio"/>	Neither agree nor disagree	<input type="radio"/>	Client refused
<input type="radio"/>	Somewhat agree	<input type="radio"/>	Data not collected

CLIENT PERCEIVES THE HAVE A TENDENCY TO BOUNCE BACK AFTER HARD TIMES *[Head of Household]*

<input type="radio"/>	Strongly disagree	<input type="radio"/>	Strongly agree
<input type="radio"/>	Somewhat disagree	<input type="radio"/>	Client doesn't know
<input type="radio"/>	Neither agree nor disagree	<input type="radio"/>	Client refused
<input type="radio"/>	Somewhat agree	<input type="radio"/>	Data not collected

CLIENT'S FREQUENCY OF FEELING NERVOUS, TENSE, WORRIED, FRUSTRATED, OR AFRAID *[Head of Household]*

<input type="radio"/>	Not at all	<input type="radio"/>	At least every day
<input type="radio"/>	Once a month	<input type="radio"/>	Client doesn't know
<input type="radio"/>	Several times a month	<input type="radio"/>	Client refused
<input type="radio"/>	Several times a week	<input type="radio"/>	Data not collected

 Signature of applicant stating all information is true and correct

Date