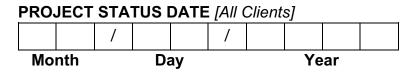


CLARITY HMIS: HUD-CoC STATUS ASSESSMENT FORM

Use block letters for text and bubble in the appropriate circles. Please complete a separate form for each household member.

CLIENT NAME OR IDENTIFIER: _



IN PERMANENT HOUSING [Permanent Housing Projects, for Head of Household]

• No	○ Yes				
IF "YES" TO PERMANENT HOUSING					
Housing Move-In Date:*	//				
*If client moved into permanent housing, make sure to update on the enrollment screen .					

PHYSICAL DISABILITY [All Clients]

• No	0	Client doesn't know		
• Yes				Client prefers not to answer
	0	Data not collected		
IF "YES" TO PHYSICAL DISABILITY – SPECIF	Ϋ́			
Expected to be of long-continued and indefinite	0	No	0	Client doesn't know
duration and substantially impairs ability to live o Yes				Client prefers not to answer
independently?			0	Data not collected

DEVELOPMENTAL DISABILITY [All Clients]

0	No	0	Client doesn't know
0	Yes	0	Client prefers not to answer
		0	Data not collected

CHRONIC HEALTH CONDITION [All Clients]

• No	0	Client doesn't know		
○ Yes	0	Client prefers not to answer		
	0	Data not collected		
IF "YES" TO CHRONIC HEALTH CONDITION				
Expected to be of long-continued and indefinite	0	No	0	Client doesn't know
duration and substantially impairs ability to live o Yes				Client prefers not to answer
independently?			0	Data not collected

HIV-AIDS [All Clients]

0	No	0	Client doesn't know
0	Yes	0	Client prefers not to answer
		0	Data not collected



MENTAL HEALTH DISORDER [All Clients]

• No	0	Client doesn't know		
○ Yes				Client prefers not to answer
	0	Data not collected		
IF "YES" TO MENTAL HEALTH DISORDER -	SPE	CIFY		
Expected to be of long-continued and indefinite	0	No	0	Client doesn't know
duration and substantially impairs ability to live o Yes				Client prefers not to answer
independently?	0	Data not collected		

SUBSTANCE USE DISORDER [All Clients]

0	No				Client doesn't know		
0	Alcohol use disorder			0	Client prefers not to answer		
0	• Drug use disorder				Data not collected		
0	Both alcohol and drug use disorders						
IF	IF "ALCOHOL USE DISORDER" "DRUG USE DISORDER" OR "BOTH ALCOHOL AND DRUG USE						
DI	DISORDERS" – SPECIFY						
Ex	pected to be of long-continued and indefinite	No	0	Client doesn't know			
du	ration and substantially impairs ability to live	0	Client prefers not to answer				
inc	lependently?			0	Data not collected		

SURVIVOR OF DOMESTIC VIOLENCE [Head of Household and Adults]

0	> No				Client doesn't know
0	Yes			0	Client prefers not to answer
				0	Data not collected
IF	"YES" TO SURVIVOR OF DOMESTIC VIOLE	E – SPEC	;IFY	WHEN EXPERIENCE OCCURRED	
0	 Within the past three months 			0	Client doesn't know
0	Three to six months ago (excluding six month	ns e	xactly)	0	Client prefers not to answer
0	Six months to one year ago (excluding one year	ear	exactly)	0	Data not collected
0	One year ago or more				
	• No			0	Client doesn't know
Are you currently fleeing? • Yes			Yes	0	Client prefers not to answer
		0	Data not collected		

INCOME FROM ANY SOURCE [Head of Household and Adults]

• No		()	Client doesn't know		
0	○ Yes)	Client prefers not to answer		
		C)	Data not collected		
IF	"YES" TO INCOME FROM ANY SOU	RCE – II	NDIC	ATE ALL SOURCES THAT APPLY		
Inc	come Source	Amount	Inc	ome Source	Amount	
0	Earned Income	0		Temporary Assistance for Needy Families (TANF)		
0	Unemployment Insurance		0	General Assistance (GA)		
0	Supplemental Security Income (SSI)		0	Retirement income from Social Security		
0	Social Security Disability Insurance (SSDI)		0	Pension or retirement income from a former job		
0	VA Service-Connected Disability Compensation		0	Child support		
0	VA Non-Service-Connected Disability Pension		0	Alimony and other spousal s upport		
0	Private disability insurance		0	Other income source (specify):		
0	Worker's Compensation					
То	tal Monthly Income for Individual:					



RECEIVING NON-CASH BENEFITS [Head of Household and Adults]

	Ľ		,				
0	No	0	Client doesn't know				
0	Yes	0	Client prefers not to answer				
		0	Data not collected				
IF	IF "YES" TO NON-CASH BENEFITS – INDICATE ALL SOURCES THAT APPLY						
0	Supplemental Nutrition Assistance Program (SNAP)	0	TANF Child Care Services				
0	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	0	TANF Transportation Services				
0	Other (specify):	0	Other TANF-funded services				

COVERED BY HEALTH INSURANCE [All Clients]

	L L		
0	No	0	Client doesn't know
0	Yes	0	Client prefers not to answer
		0	Data not collected
IF	"YES" TO HEALTH INSURANCE – HEALTH IN	ISU	RANCE COVERAGE DETAILS
0	MEDICAID	0	Employer Provided Health Insurance
0	MEDICARE	0	Health Insurance Obtained Through COBRA
0	State Children's Health Insurance (SCHIP)	0	Private Pay Health Insurance
0	Veteran's Health Administration (VHA)	0	State Health Insurance for Adults
0	Other (specify):	0	Indian Health Services Program

Signature of applicant stating all information is true and correct Date