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 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			○	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

HIV-AIDS *[All Clients]*

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

CLARITY HUMAN SERVICES

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	○	Client doesn't know
○	Alcohol use disorder	○	Client prefers not to answer
○	Drug use disorder	○	Data not collected
○	Both alcohol and drug use disorders		
IF "ALCOHOL USE DISORDER" "DRUG USE DISORDER" OR "BOTH ALCOHOL AND DRUG USE DISORDERS" – 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 – SPECIFY WHEN EXPERIENCE OCCURRED			
○	Within the past three months	○	Client doesn't know
○	Three to six months ago (excluding six months exactly)	○	Client prefers not to answer
○	Six months to one year ago (excluding one year exactly)	○	Data not collected
○	One year ago or more		
Are you currently fleeing?	○ No	○	Client doesn't know
	○ Yes	○	Client prefers not to answer
		○	Data not collected

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 **s**upport	
○	Private **d**isability **i**nsurance		○	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	○	Health Insurance Obtained Through COBRA
○	State Children's Health Insurance (SCHIP)	○	Private Pay Health Insurance
○	Veteran's 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**