2026 CLARITY PROJECT ENROLLMENT 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 START DATE​ *​*​ *​[All Clients]*

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | */* |  |  | */* |  |  |  |  |

Month DayYear

ENROLLMENT CoC *[only if multiple CoC’s] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

# 

WHEN CLIENT WAS ENGAGED ​*[Street Outreach Only or Night by Night Emergency Shelter]*

|  |  |
| --- | --- |
| Date of Engagement: | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ |

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

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Yes |
| IF “YES” TO PERMANENT HOUSING | | | |
| Housing Move-In Date: | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ | |

PRIOR LIVING SITUATION

TYPE OF RESIDENCE *[Head of Household and Adults]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport, or anywhere outside) | ○ | Hotel or motel paid for without emergency shelter voucher |
| ○ | Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or Host Home shelter | ○ | Host Home (non-crisis) |
| ○ | Safe Haven | ○ | Staying or living in a friend’s room, apartment, or house |
| ○ | Foster care home or foster care group home | ○ | Staying or living in a family member’s room, apartment or house |
| ○ | Hospital or other residential non­psychiatric medical facility | ○ | Rental by client, no ongoing housing subsidy |
| ○ | Jail, prison or juvenile detention facility | ○ | Rental by client, with ongoing housing subsidy |
| ○ | Long-term care facility or nursing home | ○ | Owned by client, with on­going housing subsidy |
| ○ | Psychiatric hospital or other psychiatric facility | ○ | Owned by client, no on­going housing subsidy |
| ○ | Substance abuse treatment facility or detox center | ○ | Client doesn’t know |
| ○ | Transitional housing for homeless persons (including homeless youth) | ○ | Client prefers not to answer |
| ○ | Residential project or halfway house with no homeless criteria | ○ | Data not collected |
| IF “RENTAL BY CLIENT, WITH ONGOING HOUSING SUBSIDY” – SPECIFY: | | | |
| ○ | GPD TIP housing subsidy | ○ | Emergency Housing Voucher |
| ○ | VASH Housing subsidy | ○ | Family Unification Program Voucher (FUP) |
| ○ | RRH or equivalent subsidy | ○ | Foster Youth to Independence Initiative (FYI) |
| ○ | HCV voucher (tenant or project based) (not dedicated) | ○ | Permanent Supportive Housing |
| ○ | Public Housing Unit | ○ | Other permanent housing dedicated for formerly homeless persons |
| ○ | Rental by client, with other ongoing housing subsidy |

LENGTH OF STAY IN PRIOR LIVING SITUATION

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ○ | One night or less | ○ | One month or more, but less than 90 days | ○ | Client doesn’t know |
| ○ | Two to six nights | ○ | 90 days or more, but less than one year | ○ | Client prefers not to answer |
| ○ | One week or more, but less than one month | ○ | One year or longer | ○ | Data not collected |

LENGTH OF STAY LESS THAN 7 NIGHTS *[TH, PH]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Yes |

LENGTH OF STAY LESS THAN 90 DAYS [*Institutional Housing Situations]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Yes |

ON THE NIGHT BEFORE – STAYED ON THE STREETS, EMERGENCY SHELTER, SAFE HAVEN *[Head of Household and Adults]*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ○ | Yes | ○ | | No |
| Approximate Date This Episode of Homelessness Started | | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ | |
| Number of *times* the client has been on the streets, ES, or Safe Haven in the last 3 years | | | | |
| ○ | One Time | ○ | | Client doesn’t know |
| ○ | Two Times | ○ | | Client prefers not to answer |
| ○ | Three Times | ○ | | Data not collected |
| ○ | Four or More Times |  | | |
| Total number of *months* homeless on the streets, ES, or Safe Haven in the last 3 years | | | | |
| ○ | One month (this time is the first month) | ○ | | Client doesn’t know |
| ○ | 2­12 months (specify number of months): \_\_\_\_\_\_\_\_ | ○ | | Client prefers not to answer |
| ○ | More than 12 months | ○ | | Data not collected |

DISABLING CONDITION ​*[All Clients]*

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

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 |

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 support |  |
| ○ | Private disability insurance |  | | ○ | 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