

Agency Name: _____



CLARITY HMIS: HUD - CoC PROJECT 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]*

| | |
|--|---------------------------|
| <input type="radio"/> No | <input type="radio"/> Yes |
| IF "YES" TO PERMANENT HOUSING | |
| Housing Move-In Date:* | ____/____/____ |
| <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 prefers not to answer | |
| | <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 prefers not to answer |
| | | <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 prefers not to answer |
| | <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 prefers not to answer | |
| | <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 prefers not to answer |
| | | <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 prefers not to answer |
| | <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 prefers not to answer | |
| | <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 prefers not to answer |
| | | <input type="radio"/> Data not collected |

SUBSTANCE USE DISORDER [All Clients]

| | | |
|---|--|--|
| <input type="radio"/> No | <input type="radio"/> Client doesn't know | |
| <input type="radio"/> Alcohol use disorder | <input type="radio"/> Client prefers not to answer | |
| <input type="radio"/> Drug use disorder | <input type="radio"/> Data not collected | |
| <input type="radio"/> 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? | <input type="radio"/> No | <input type="radio"/> Client doesn't know |
| | <input type="radio"/> Yes | <input type="radio"/> Client prefers not to answer |
| | | <input type="radio"/> Data not collected |

SURVIVOR OF DOMESTIC VIOLENCE [Head of Household and Adults]

| | | |
|---|--|--|
| <input type="radio"/> No | <input type="radio"/> Client doesn't know | |
| <input type="radio"/> Yes | <input type="radio"/> Client prefers not to answer | |
| | <input type="radio"/> Data not collected | |
| IF "YES" TO SURVIVOR OF DOMESTIC VIOLENCE – SPECIFY WHEN EXPERIENCE OCCURRED | | |
| <input type="radio"/> Within the past three months | <input type="radio"/> Client doesn't know | |
| <input type="radio"/> Three to six months ago (excluding six months exactly) | <input type="radio"/> Client prefers not to answer | |
| <input type="radio"/> Six months to one year ago (excluding one year exactly) | <input type="radio"/> Data not collected | |
| <input type="radio"/> One year ago or more | | |
| Are you currently fleeing? | <input type="radio"/> No | <input type="radio"/> Client doesn't know |
| | <input type="radio"/> Yes | <input type="radio"/> Client prefers not to answer |
| | | <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 prefers not to answer | | |
| | <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 (<i>specify</i>): | |
| <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 prefers not to answer |

| | | |
|--|---|-----------------------|
| | <input type="radio"/> | Data not collected |
| IF "YES" TO NON-CASH BENEFITS – INDICATE ALL SOURCES THAT APPLY | | |
| <input type="radio"/> | Supplemental Nutrition Assistance Program (SNAP) | <input type="radio"/> |
| <input type="radio"/> | TANF Child Care Services | |
| <input type="radio"/> | Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) | <input type="radio"/> |
| <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 prefers not to answer |
| | | <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"/> | Health Insurance Obtained Through COBRA |
| <input type="radio"/> | State Children's Health Insurance (SCHIP) | <input type="radio"/> | Private Pay Health Insurance |
| <input type="radio"/> | Veteran's Health Administration (VHA) | <input type="radio"/> | State Health Insurance for Adults |
| <input type="radio"/> | Other (specify): | <input type="radio"/> | Indian Health Services Program |

Signature of applicant stating all information is true and correct
Date