Agency Name: _____

CLARITY HMIS: HUD-COC STATUS ASSESSMENT FORM

Use block letters for text and mark appropriate boxes with an "X". Complete a separate form for each household member.

ASSESSMENT DATE *[All Clients]*

		-			-				
Month			*Day*			*Year*			

CURRENT NAME [*All Clients*]

																	N/A
Last																	
First																	
Middle																	☐
Suffix																	☐

IN PERMANENT HOUSING *[RRH PROGRAMS ONLY - All Clients]*

☐	Yes	☐	No

IF "YES" TO PERMANENT HOUSING	
Date of Move-In	____/____/_____

DISABLING CONDITION *[All Adults]*

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused
		☐	Data not collected

PHYSICAL DISABILITY *[All Clients]*

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused
		☐	Data not collected

IF "YES" TO PHYSICAL DISABILITY – SPECIFY				
Currently receiving services for physical disability	☐	No	☐	Client doesn't know
	☐	Yes	☐	Client refused
			☐	Data not collected
Long-term physical disability	☐	No	☐	Client doesn't know
	☐	Yes	☐	Client refused

			☐	Data not collected
Documentation of the disability and severity on file	☐	No	☐	Yes

DEVELOPMENTAL DISABILITY *[All Clients]*

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused
		☐	Data not collected

IF "YES" TO DEVELOPMENTAL DISABILITY – SPECIFY				
Currently receiving services for developmental disability	☐	No	☐	Client doesn't know
	☐	Yes	☐	Client refused
			☐	Data not collected
Expected to substantially impair independence	☐	No	☐	Client doesn't know
	☐	Yes	☐	Client refused
			☐	Data not collected
Documentation of the disability and severity on file	☐	No	☐	Yes

CHRONIC HEALTH CONDITION *[All Clients]*

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused
		☐	Data not collected

IF "YES" TO CHRONIC HEALTH CONDITION – SPECIFY				
Currently receiving services/treatment for this condition	☐	No	☐	Client doesn't know
	☐	Yes	☐	Client refused
			☐	Data not collected
Long-term chronic health condition	☐	No	☐	Client doesn't know
	☐	Yes	☐	Client refused
			☐	Data not collected
Documentation of the disability and severity on file	☐	No	☐	Yes

HIV-AIDS *[All Clients]*

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused
		☐	Data not collected

IF "YES" TO HIV-AIDS – SPECIFY				
Currently receiving services/treatment for this condition	☐	No	☐	Client doesn't know
	☐	Yes	☐	Client refused
			☐	Data not collected
Expected to substantially impair independence	☐	No	☐	Client doesn't know
	☐	Yes	☐	Client refused
			☐	Data not collected
Documentation of the disability and severity on file	☐	No	☐	Yes

CLARITY HUMAN SERVICES

MENTAL HEALTH PROBLEM *[All Clients]*

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused
		☐	Data not collected

IF "YES" TO MENTAL HEALTH PROBLEM – SPECIFY				
Currently receiving services/treatment for this condition	☐	No	☐	Client doesn't know
	☐	Yes	☐	Client refused
			☐	Data not collected
Long-term mental health problem	☐	No	☐	Client doesn't know
	☐	Yes	☐	Client refused
			☐	Data not collected
Documentation of the disability and severity on file	☐	No	☐	Yes

SUBSTANCE ABUSE PROBLEM *[All Clients]*

☐	No	☐	Both alcohol and drug abuse
☐	Alcohol abuse	☐	Client doesn't know
		☐	Client refused
☐	Drug abuse	☐	Data not collected

IF "ALCOHOL ABUSE" "DRUG ABUSE" OR "BOTH ALCOHOL AND DRUG ABUSE" – SPECIFY				
Currently receiving services/treatment for this condition	☐	No	☐	Client doesn't know
	☐	Yes	☐	Client refused
			☐	Data not collected
Long-term substance abuse problem	☐	No	☐	Client doesn't know
	☐	Yes	☐	Client refused
			☐	Data not collected
Documentation of the disability and severity on file	☐	No	☐	Yes

DOMESTIC VIOLENCE *[Head of Household and Adults]*

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused
		☐	Data not collected

IF "YES" TO DOMESTIC VIOLENCE - WHEN EXPERIENCE OCCURRED			
Last Occurrence			
☐	Within the past three months	☐	One year ago or more
☐	Three to six months ago (excluding six months exactly)	☐	Client doesn't know
		☐	Client refused
☐	Six months to one year ago (excluding one year exactly)	☐	Data not collected
Are you currently fleeing?	☐	No	☐	Client doesn't know
	☐	Yes	☐	Client refused

		☐	Data not collected

INCOME FROM ANY SOURCE *[Head of Household and Adults]*

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused
		☐	Data not collected

IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY

	Income Source	Amount		Income Source	Amount
☐	Earned Income		☐	TANF (Temporary Assistance for Needy Families)	
☐	Unemployment Insurance		☐	General Assistance (GA)	
☐	Supplemental Security Income (SSI)		☐	Retirement Income from Social Security	
☐	Social Security Disability Income (SSDI)		☐	Pension or retirement income from former job	
☐	VA Service-Connected Disability Compensation		☐	Child support	
☐	VA Non-Service Connected Disability Pension		☐	Alimony and other spousal support	
☐	Private disability insurance		☐	Other source	
☐	Worker's Compensation		Specify "Other"		
Total monthly amount:					

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

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused
		☐	Data not collected

IF "YES" TO NON-CASH BENEFITS – INDICATE ALL SOURCES THAT APPLY

☐	SNAP	☐	Other TANF Benefit
☐	WIC	☐	Section 8
☐	TANF Childcare	☐	Other Source
☐	TANF Transportation	☐	Temporary Rental Assistance
Specify "Other"			

COVERED BY HEALTH INSURANCE *[All Clients]*

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused
		☐	Data not collected

IF "YES" TO HEALTH INSURANCE - HEALTH INSURANCE COVERAGE DETAILS

☐	MEDICAID	☐	Employer Provided
☐	MEDICARE	☐	Obtained through COBRA
☐	SCHIP	☐	Private Pay Health Insurance

☐	VA Medical	☐	State Health Insurance for Adults

Signature of applicant stating all information is true and correct **Date**