

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.

ASSESSMENT DATE *[All Clients]*

		-			-				
Month			Day			Year			

CURRENT NAME <i>[All Clients]</i>	N/A
Last	○
First	
Middle	
Suffix	

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

<input type="radio"/> No	<input type="radio"/> Yes
IF "YES" TO PERMANENT HOUSING	
Date of Move-In	___/___/_____

DISABLING CONDITION *[All Clients]*

<input type="radio"/> No	<input type="radio"/> Client doesn't know
<input type="radio"/> Yes	<input type="radio"/> Client refused
	<input type="radio"/> Data not collected

PHYSICAL DISABILITY *[All Clients]*

<input type="radio"/> No	<input type="radio"/> Client doesn't know
<input type="radio"/> Yes	<input type="radio"/> Client refused
	<input type="radio"/> Data not collected

IF "YES" TO PHYSICAL DISABILITY – SPECIFY

Currently receiving services for physical disability	<input type="radio"/>	No	<input type="radio"/>	Client doesn't know
	<input type="radio"/>	Yes	<input type="radio"/>	Client refused
			<input type="radio"/>	Data not collected
Long-term physical disability	<input type="radio"/>	No	<input type="radio"/>	Client doesn't know
	<input type="radio"/>	Yes	<input type="radio"/>	Client refused
			<input type="radio"/>	Data not collected
Documentation of the disability and severity on file	<input type="radio"/>	No	<input type="radio"/>	Yes

DEVELOPMENTAL DISABILITY *[All Clients]*

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

CHRONIC HEALTH CONDITION *[All Clients]*

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

HIV-AIDS *[All Clients]*

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

MENTAL HEALTH PROBLEM *[All Clients]*

<input type="radio"/> No	<input type="radio"/> Client doesn't know
<input type="radio"/> Yes	<input type="radio"/> Client refused
	<input type="radio"/> Data not collected

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

SUBSTANCE ABUSE PROBLEM *[All Clients]*

<input type="radio"/>	No	<input type="radio"/>	Both alcohol and drug abuse
<input type="radio"/>	Alcohol abuse	<input type="radio"/>	Client doesn't know
		<input type="radio"/>	Client refused
<input type="radio"/>	Drug abuse	<input type="radio"/>	Data not collected

IF "ALCOHOL ABUSE" "DRUG ABUSE" OR "BOTH ALCOHOL AND DRUG ABUSE" – SPECIFY

Currently receiving services/treatment for this condition	<input type="radio"/>	No	<input type="radio"/>	Client doesn't know
	<input type="radio"/>	Yes	<input type="radio"/>	Client refused
	<input type="radio"/>		Data not collected	
Long-term substance abuse problem	<input type="radio"/>	No	<input type="radio"/>	Client doesn't know
	<input type="radio"/>	Yes	<input type="radio"/>	Client refused
	<input type="radio"/>		Data not collected	
Documentation of the disability and severity on file	<input type="radio"/>	No	<input type="radio"/>	Yes

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 refused
		<input type="radio"/>	Data not collected

IF "YES" TO DOMESTIC VIOLENCE

LAST OCCURRENCE

<input type="radio"/>	Within the past three months	<input type="radio"/>	One year ago or more	
<input type="radio"/>	Three to six months ago (excluding six months exactly)	<input type="radio"/>	Client doesn't know	
		<input type="radio"/>	Client refused	
<input type="radio"/>	Six months to one year ago (excluding one year exactly)	<input type="radio"/>	Data not collected	
Are you currently fleeing?	<input type="radio"/>	No	<input type="radio"/>	Client doesn't know
	<input type="radio"/>	Yes	<input type="radio"/>	Client refused
	<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 refused
	<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"/> TANF (Temporary Assist for Needy Families)		<input type="radio"/> Earned Income	
<input type="radio"/> Unemployment Insurance		<input type="radio"/> General Assistance (GA)	
<input type="radio"/> Supplemental Security Income (SSI)		<input type="radio"/> Private disability insurance	
<input type="radio"/> Social Security Disability Income (SSDI)		<input type="radio"/> Pension or retirement income from former job	
<input type="radio"/> VA Service-Connected Disability Compensation		<input type="radio"/> Child support	
<input type="radio"/> VA Non-Service Connect Disability Pensioned		<input type="radio"/> Alimony and other spousal support	
<input type="radio"/> Retirement Income from Social Security		<input type="radio"/> Other source	
<input type="radio"/> Worker's Compensation		Specify Other"	
Total monthly amount:			

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 refused
	<input type="radio"/> Data not collected

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

<input type="radio"/> SNAP	<input type="radio"/> Other TANF Benefit
<input type="radio"/> WIC	<input type="radio"/> Section 8
<input type="radio"/> TANF Childcare	<input type="radio"/> Temporary Rental Assistance
<input type="radio"/> TANF Transportation	<input type="radio"/> Other (Specify):

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 refused
	<input type="radio"/> Data not collected

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

<input type="radio"/> MEDICAID	<input type="radio"/> Employer Provided
<input type="radio"/> MEDICARE	<input type="radio"/> Obtained through COBRA
<input type="radio"/> SCHIP	<input type="radio"/> Private Pay Health Insurance
<input type="radio"/> VA Medical	<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