Agency Name: _____

CLARITY HMIS: HHS/HUD-RYH + 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 *[All Clients]*																			**N/A**
Last																			○
First																			
Middle																			○
Suffix																			○

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

○	No	○	Yes
IF "YES" TO PERMANENT HOUSING			
Date of Move-In	____/____/_____		

DISABLING CONDITION *[All Clients]*

○	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

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

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**
○	TANF (Temporary Assist for Needy Families)		○	Earned Income	
○	Unemployment Insurance		○	General Assistance (GA)	
○	Supplemental Security Income (SSI)		○	Private disability insurance	
○	Social Security Disability Income (SSDI)		○	Pension or retirement income from former job	
○	VA Service-Connected Disability Compensation		○	Child support	

○	VA Non-Service Connect Disability Pensioned		○	Alimony and other spousal support	
○	Retirement Income from Social Security		○	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	○	Temporary Rental Assistance
○	TANF Transportation	○	Other (**Specify):**

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
○	Other (specify)	○	Indian Health Services Program

RHY SPECIFIC YOUTH INFORMATION

PREGNANCY STATUS *[All Female: HoH, Adults and Unaccompanied Youth]*

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected
IF "YES" for Pregnancy Status			
Due Date	____/____/_____		

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