

Agency Name: \_\_\_\_\_



## CLARITY HMIS: HHS-RHY PROGRAM STATUS UPDATE 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			

CLIENT LOCATION *[only if multiple CoC's]* \_\_\_\_\_

**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**

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

**IF "YES" TO DEVELOPMENTAL DISABILITY – SPECIFY**

Expected to substantially impair ability to live independently?	<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

**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**

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

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

**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		
<b>IF "YES" TO MENTAL HEALTH CONDITION – SPECIFY</b>					
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 refused
				<input type="radio"/>	Data not collected

**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"/>	Drug abuse	<input type="radio"/>	Client refused		
		<input type="radio"/>	Data not collected		
<b>IF "ALCOHOL ABUSE" "DRUG ABUSE" OR "BOTH ALCOHOL AND DRUG ABUSE" – SPECIFY</b>					
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 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	
<b>IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY</b>				
<b>Income Source</b>		<b>Amount</b>	<b>Income Source</b>	<b>Amount</b>
<input type="radio"/>	Alimony and other spousal support		<input type="radio"/>	Child support
<input type="radio"/>	Pension or retirement income from former job		<input type="radio"/>	Earned Income
<input type="radio"/>	Retirement Income from Social Security		<input type="radio"/>	General Assistance (GA)
<input type="radio"/>	Social Security Disability Insurance (SSDI)		<input type="radio"/>	Private disability insurance
<input type="radio"/>	Supplemental Security Income (SSI)		<input type="radio"/>	Unemployment Insurance
<input type="radio"/>	TANF (Temporary Assist for Needy Families)		<input type="radio"/>	Worker's Compensation
<input type="radio"/>	VA Service Connected Disability Compensation		<input type="radio"/>	Other source
<input type="radio"/>	VA Non--Service Connected Disability Pension		Other (specify):	
<b>Total monthly amount:</b>				

**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
<b>IF "YES" TO NON-CASH BENEFITS – INDICATE ALL SOURCES THAT APPLY</b>			
<input type="radio"/>	Supplemental Nutrition Assistance Program (SNAP)	<input type="radio"/>	TANF Childcare Services
<input type="radio"/>	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	<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 refused
		<input type="radio"/>	Data not collected
<b>IF "YES" TO HEALTH INSURANCE - HEALTH INSURANCE COVERAGE DETAILS</b>			
<input type="radio"/>	MEDICAID	<input type="radio"/>	Employer Provided Health Insurance
<input type="radio"/>	MEDICARE	<input type="radio"/>	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 Administration (VA) Medical Services	<input type="radio"/>	State Health Insurance for Adults
<input type="radio"/>	Other (specify):	<input type="radio"/>	Indian Health Services Program

## RHY SPECIFIC YOUTH INFORMATION

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

<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
<b>IF "YES" for Pregnancy Status</b>			
<b>Due Date</b>		____/____/____	

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