

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.

CLIENT NAME OR IDENTIFIER: \_\_\_\_\_

### PROJECT STATUS DATE [All Clients]

|       |     |  |      |  |  |  |  |
|-------|-----|--|------|--|--|--|--|
|       |     |  | / -  |  |  |  |  |
| Month | Day |  | Year |  |  |  |  |

### IN PERMANENT HOUSING [Permanent Housing Projects, for Heads of Households]

|  |                           |
|--|---------------------------|
| <input type="radio"/> No   | <input type="radio"/> Yes |
| <b>IF "YES" TO PERMANENT HOUSING</b>   |                           |
| <b>Housing Move-In Date:</b> (See Note*) ____/____/____  |                           |
| <small>*If client moved into permanent housing, make sure to update on the <b>enrollment screen</b>.</small> |                           |

### 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           |
| <b>IF "YES" TO PHYSICAL DISABILITY – 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 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           |
| <b>IF "YES" TO CHRONIC 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 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"/> | Both alcohol and drug use disorder |
| <input type="radio"/> | Alcohol use disorder | <input type="radio"/> | Client doesn't know                |
| <input type="radio"/> |                      | <input type="radio"/> | Client prefers not to answer       |
| <input type="radio"/> | Drug use disorder    | <input type="radio"/> | Data not collected                 |

**IF "ALCOHOL USE DISORDER" "DRUG USE DISORDER" OR "BOTH ALCOHOL AND DRUG USE 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           |

**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"/> |     | <input type="radio"/> | Data not collected           |

**IF "YES" TO SURVIVORS OF DOMESTIC VIOLENCE**
**WHEN EXPERIENCE OCCURRED**

|                       |   |                       |                              |
|-----------------------|---|-----------------------|------------------------------|
| <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"/> |   | <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           |

|                            |                       |     |                       |                              |
|----------------------------|-----------------------|-----|-----------------------|------------------------------|
| 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 (specify):                 |               |        |
| <input type="radio"/> Worker's Compensation                        |  |               |        |
| <b>Total Monthly Income for Individual:</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 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"/> TANF Child Care 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 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"/> Insurance Obtained through COBRA   |
| <input type="radio"/> State Children's Health Insurance (SCHIP) | <input type="radio"/> Private Pay Health Insurance       |
| <input type="radio"/> Veterans Health Administration (VHA)      | <input type="radio"/> State Health Insurance for Adults  |
| <input type="radio"/> Other (specify):                          | <input type="radio"/> Indian Health Services Program     |



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

**Date**