

Alameda County HMIS



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 Head of Household]*

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

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	
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 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	
IF "YES" TO CHRONIC HEALTH CONDITION – SPECIFY		
	<input type="radio"/> No	<input type="radio"/> Client doesn't know
	<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	<input type="radio"/>	Data not collected
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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"/>	Client doesn't know
<input type="radio"/> Alcohol use disorder	<input type="radio"/>	Client prefers not to answer
<input type="radio"/> Drug use disorder	<input type="radio"/>	Data not collected
<input type="radio"/> Both alcohol and drug use disorders		
IF "ALCOHOL USE DISORDER" "DRUG USE DISORDER" OR "BOTH ALCOHOL AND DRUG USE DISORDERS" – 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

Have you experienced a past or current relationship that was controlling and/or abusive? This includes domestic violence, dating violence, sexual assault, stalking, and human trafficking. *[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" When was the last time that you felt unsafe or threatened in a relationship?		
<input type="radio"/> Within the past three months	<input type="radio"/>	Client doesn't know
<input type="radio"/> Three to six months ago (excluding six months exactly)	<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
<input type="radio"/> One year ago or more		
Are you currently seeking safety from a relationship that is controlling and/or	<input type="radio"/> No	<input type="radio"/> Client doesn't know
	<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer

abusive? This includes domestic violence, dating violence, sexual assault, stalking, and human trafficking.	<input type="radio"/>	Data not collected
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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			

Total Monthly Income for Individual:

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
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<input type="radio"/>	MEDICARE	<input type="radio"/>	Health 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 Health Administration (VHA)	<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