

Agency Name: _____



CLARITY HMIS: VA SERVICES STATUS FORM (Including HUD VASH, SSVF, GPD)

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]* _____

PHYSICAL DISABILITY *[not required for SSVF]*

<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?		<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 *[not required for SSVF]*

<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 *[not required for SSVF]*

<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?		<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

HIV-AIDS *[not required for SSVF]*

<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
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MENTAL HEALTH PROBLEM [not required for SSVF]

<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 PROBLEMS – SPECIFY

Expected to be of long-continued and indefinite duration?	<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 [not required for SSVF]

<input type="radio"/>	No	<input type="radio"/>	Both alcohol & 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

Expected to be of long-continued and indefinite duration?	<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

DOMESTIC VIOLENCE VICTIM/ SURVIVOR [Heads of Household & Adults]

Domestic Violence Victim/Survivor	<input type="radio"/>	No
	<input type="radio"/>	Yes

If "YES" to DOMESTIC VIOLENCE VICTIM/ SURVIVOR- COMPLETE

LAST OCCURRENCE	____ / ____ / ____	
Are you currently fleeing?	<input type="radio"/>	Yes
	<input type="radio"/>	No
	<input type="radio"/>	Client doesn't know
	<input type="radio"/>	Client refused
	<input type="radio"/>	Data not collected

MONTHLY INCOME AND SOURCES [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

				○ Data not collected	
IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY					
Income Source		Amount	Income Source		Amount
○	Earned Income		○	TANF (Temporary Assist for Needy Families)	
○	Unemployment Insurance		○	General Assistance (GA)	
○	Supplemental Security Income (SSI)		○	Retirement Income from Social Security	
○	Social Security Disability Insurance (SSDI)		○	Pension or retirement income from former job	
○	VA Service-Connected Disability Compensation		○	Child Support	
○	VA Non-Service Connected Disability Pension		○	Alimony and other spousal support	
○	Private disability insurance		○	Other income source	
○	Worker's Compensation		○	Other income source	
Total monthly income for Individual:					

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

○	Supplemental Nutrition Assistance Program (SNAP)	○	TANF Childcare Services
○	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	○	TANF Transportation Services
○	Other (specify):	○	Other TANF-funded services

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 Health Insurance
○	MEDICARE	○	Insurance Obtained through COBRA
○	State Children's Health Insurance (SCHIP)	○	Private Pay Health Insurance
○	Veteran's Administration (VA) Medical Services	○	State Health Insurance for Adults
○	Other (specify)	○	Indian Health Services Program



CONNECTION WITH SOAR [*Heads of Households and Adults, For SSVF and VA: Grant per Diem – Case Management/Housing Retention*]

<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

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

<input type="radio"/> No	<input type="radio"/> Yes
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IF "YES" TO PERMANENT HOUSING

Housing Move-in Date (see note*)	<i>*If client moved into permanent housing, make sure to update on the enrollment screen.</i>
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Signature of applicant stating all information is true and correct Date