

N/A

Agency Name: _____

CLARITY HMIS: HUD-COC STATUS ASSESSMENT FORM

Use block letters for text and mark appropriate boxes with an "X". Complete a separate form for each household member.

ASSESSMENT DATE [All Clients]									
		-			-				
Month			Day			Yea	r		-

CURRENT NAME [All Clients]

			-						
Last									
First									
Middle									
Suffix									

IN PERMANENT HOUSING [RRH PROGRAMS ONLY - All Clients]

Yes	No					
IF "YES" TO PERMANENT HOUSING						
Date of Move-In	<u>//</u>					

DISABLING CONDITION [All Adults]

No	Client doesn't know
Yes	Client refused
165	Data not collected

PHYSICAL DISABILITY [All Clients]

No		Client doesn't know						
Yes Client refused								
165		ted						
IF "YES" TO PHYSICAL DISABILITY – SPECIFY								
Our man and here			No	Client doesn't know				
disability	receiving services fo	or physical	Yes	Client refused				
disability			res	Data not collected				
Long-term	n physical disability		No	Client doesn't know				



			HUMAN
	Voc		Client refused
	Yes		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						
	165	Data not collected						
IF "Y	IF "YES" TO DEVELOPMENTAL DISABILITY – SPECIFY							
Currently receiving services for developmental disability			No		Client doesn't know			
			Ye	6	Client refused			
uisai	Sincy		10	5	Data not collected			
			No		Client doesn't know			
Expected to substantially impair independence		air independence	Ye		Client refused			
			10	5	Data not collected			
Docι	umentation of the disabili	ity and severity on file	1	lo	Yes			

CHRONIC HEALTH CONDITION [All Clients]

		<u> </u>							
	No	Client doesn't kno	w						
	Yes	Client refused	Client refused						
165		Data not collected	Data not collected						
IF "Y	IF "YES" TO CHRONIC HEALTH CONDITION – SPECIFY								
				No		Client doesn't know			
	Currently receiving services/treatment for this condition			Yes		Client refused			
cond				165		Data not collected			
				No		Client doesn't know			
Long	Long-term chronic health condition			Yes		Client refused			
				163		Data not collected			
Docu	imentation of the disability	ity and severity on file		No		Yes			

HIV-AIDS [All Clients]

N	lo	Client doesn't kn	Client doesn't know						
V	/ 05	Client refused							
Yes		Data not collecte	Data not collected						
IF "YES" TO HIV-AIDS – SPECIFY									
Current	Currently receiving services/treatment for this			Client doesn't know					
conditio		reatment for this	Yes	Client refused					
conditio	011		Tes	Data not collected					
Expected to substantially impair indepe		air independence	No	Client doesn't know					
			Yes	Client refused					

				ARITY N SERVICES
			Data not collected	
Documentation of the disability and severity on file	No)	Yes	

MENTAL HEALTH PROBLEM [All Clients]

	No		Client doesn't kno	W						
	Yes		Client refused	Client refused						
			Data not collected							
IF "Y	IF "YES" TO MENTAL HEALTH PROBLEM – SPECIFY									
Currently receiving services/treatment for this condition				No		Client doesn't know				
			ment for this		Yes		Client refused			
conu					165		Data not collected			
					No		Client doesn't know			
Long-term mental health problem		olem			Yes		Client refused			
				163		Data not collected				
Docu	imentation of the disabili	ity ar	nd severity on file		No		Yes			

SUBSTANCE ABUSE PROBLEM [All Clients]

	No	Both alcohol and drug abuse		Both alcohol and drug abuse							
	Alcohol abuse	Client doesn't know									
	Client refused										
	Drug abuse	Data not collected	Data not collected								
IF "ALCOHOL ABUSE" "DRUG ABUSE" OR "BOTH ALCOHOL AND DRUG ABUSE" – SPECIFY											
Currently receiving services/treatment for this				No	Client doesn't know						
	dition	services/treatment for this	,	res –	Client refused						
con	anion			165	Data not collected						
			1	No	Client doesn't know						
Lon	Long-term substance abuse problem			res –	Client refused						
					Data not collected						
Doc	Documentation of the disability and severity on file				Yes						
-00		ie aleasing and covering on me		No							

DOMESTIC VIOLENCE [Head of Household and Adults]

	No	Client doesn't know	Client doesn't know				
Yes		Client refused	Client refused				
	165	Data not collected					
IF "Y	IF "YES" TO DOMESTIC VIOLENCE - WHEN EXPERIENCE OCCURRED						
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			
	Three to six months ago	(excluding six months exactly)		Client refused			
	Six months to one year ago (excluding one year exactly)			Data not collected			



	No	Client doesn't know
Are you currently fleeing?	Yes	Client refused
		Data not collected

INCOME FROM ANY SOURCE [Head of Household and Adults]

No			esn't know			
	Client doesn't know					
Yes	Client refused					
100	Data not collected					
IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY						
Income Source Amour			t Income Source			
Earned Income			TANF (Temporary Assistance			
			for Needy Families)			
Unemployment Insurance			General Assistance (GA)			
Supplemental Security			Retirement Income from Social			
Income (SSI)			Security			
Social Security Disability			Pension or retirement income			
Income (SSDI)			from former job			
VA Service-Connected			Child support			
Disability Compensation						
VA Non-Service Connecte			Alimony and other spousal			
Disability Pension			support			
Private disability insurance			Other source			
Worker's Compensation			ecify "Other"			
Total monthly amount:						

RECEIVING NON-CASH BENEFITS [Head of Household and Adults]

	No	Client doesn't know				
	Yes	Client refused				
	165	Data n	Data not collected			
IF "	IF "YES" TO NON-CASH BENEFITS – INDICATE ALL SOURCES THAT APPLY					
	SNAP			Other TANF Benefit		
	WIC			Section 8		
	TANF Childcare			Other Source		
	TANF Transportation			Temporary Rental Assistance		
Spe	Specify "Other"					

COVERED BY HEALTH INSURANCE [All Clients]

	No		Client doesn't know			
Yes		Client refused				
	165		Data not collected			
IF "YES" TO HEALTH INSURANCE - HEALTH INSURANCE COVERAGE DETAILS						
IF "Y	ES" TO HEALTH INSUR	ANC	E - HEALTH INSURANCE COVERAGE DETAILS			
IF "Y	ES" TO HEALTH INSURA MEDICAID (MassHealth)	-	E - HEALTH INSURANCE COVERAGE DETAILS Employer Provided			



SCHIP	Private Pay Health Insurance	
VA Medical	State Health Insurance for Adults (ConnectorCare)	