CLARITY HMIS: KC- HHS-RHY-CoC 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: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

PROGRAM STATUS DATE​ *​[All Clients]*

|  |  | *­* |  |  | *­* |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |

Month DayYear

ENROLLMENT CoC*[only if multiple CoC’s] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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

| ○ | No | ○ | Yes |
| --- | --- | --- | --- |
| IF “YES” TO PERMANENT HOUSING | | | |
| Housing Move-In Date: (See *Note\**) | | | *\*If client moved into permanent housing, make sure to update on the* ***enrollment screen****.* |

# **SURVIVOR OF DOMESTIC VIOLENCE** ​[Head of Household and Adults] Has the individual/client experienced a past or current relationship of any type that broke down or was unhealthy, controlling and/or abusive? (This includes domestic violence, dating violence, sexual assault, and stalking.)

| ○ | No | ○ | | | Client doesn’t know | | |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ○ | Yes | ○ | | | Client prefers not to answer | | |
| ○ | | | Data not collected | | |
| IF “YES” TO DOMESTIC VIOLENCE | | | | | | | |
| WHEN EXPERIENCE OCCURRED | | | | | | | |
| ○ | Within the past three months | | ○ | One year ago or more | | | |
| ○ | Three to six months ago (excluding six months exactly) | | ○ | Client doesn’t know | | | |
| ○ | Client prefers not to answer | | | |
| ○ | Six months to one year ago (excluding one year exactly) | | ○ | Data not collected | | | |
| Are you currently fleeing? | | | ○ | No | | ○ | Client doesn’t know |
| ○ | Yes | | ○ | Client prefers not to answer |
| ○ | Data not collected |

*\*If individual/client is currently fleeing or attempting to flee domestic violence please provide the Washington Coalition Against Domestic Violence Hotline at:* 877-737-0242 or 206-737-0242

DISABLING CONDITION ​*[All Individuals/Clients]*

*If individual/client is in need of resources, contact the following as appropriate:*

* *For aging or disability support, call the Community Living Connections Line at: 206-962-8467/1-844-348-5464(Toll Free),*
* *For crisis services: Crisis Connections at: 1-866-427-4747,*
* *For mental health or substance use services: King County Behavioral Health Recovery Client Services Line: 1-800-790-8049,*
* *For confidential peer support: Washington Warm Line 1-877-500-WARM(9276).*

DOES THE INDIVIDUAL/CLIENT HAVE:

PHYSICAL DISABILITY​ and/or a PHYSICAL HEALTH CONDITION ​*[All Individuals/Clients]*

| ○ | No | | | ○ | Client doesn’t know |
| --- | --- | --- | --- | --- | --- |
| ○ | Yes | | | ○ | Client prefers not to answer |
| ○ | 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? | | ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
| ○ | Data not collected |

DEVELOPMENTAL DISABILITY ​*[All Individuals/Clients]*

| ○ | No | ○ | Client doesn’t know |
| --- | --- | --- | --- |
| ○ | Yes | ○ | Client prefers not to answer |
| ○ | Data not collected |

CHRONIC HEALTH CONDITION ​​*[All Individuals/Clients]*

| ○ | No | ○ | Client doesn’t know |
| --- | --- | --- | --- |
| ○ | Yes | ○ | Client prefers not to answer |
| ○ | 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? | ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
| ○ | Data not collected |

MENTAL HEALTH CONDITION ​​*[All Individuals/Clients]*

| ○ | No | ○ | Client doesn’t know |
| --- | --- | --- | --- |
| ○ | Yes | ○ | Client prefers not to answer |
| ○ | Data not collected |

| IF “YES” TO MENTAL HEALTH CONDITION – SPECIFY | | | | |
| --- | --- | --- | --- | --- |
| Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? | ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
| ○ | Data not collected |

SUBSTANCE ABUSE ISSUE ​*[All Individuals/Clients]*

| ○ | No | ○ | Both alcohol and drug use disorder | | |
| --- | --- | --- | --- | --- | --- |
| ○ | Alcohol use disorder | ○ | Client doesn’t know | | |
| ○ | Client prefers not to answer | | |
| ○ | Drug use disorder | ○ | 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? | | ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
| ○ | Data not collected |

# 

# **INCOME FROM ANY SOURCE** ​[Head of Household and Adults]

| ○ | No | | | | ○ | Client doesn’t know | |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ○ | Yes | | | | ○ | Client prefers not to answer | |
| ○ | Data not collected | |
| IF “YES” TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY | | | | | | | |
| Income Source | | Amount | Income Source | | | | Amount |
| ○ | Earned Income |  | ○ | Temporary Assistance for Needy Families (TANF) | | |  |
| ○ | Unemployment Insurance |  | ○ | General Assistance (GA) | | |  |
| ○ | Supplemental Security Income (SSI) |  | ○ | Retirement Income from Social Security | | |  |
| ○ | Social Security Disability Insurance (SSDI) |  | ○ | Pension or Retirement Income from a 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 |  |  | | | | |
| Total Monthly Income for Individual: | |  | | | | | |

# **RECEIVING NON ­CASH BENEFITS**​ ​[Head of Household and Adults]

| ○ | No | ○ | Client doesn’t know |
| --- | --- | --- | --- |
| ○ | Yes | ○ | Client prefers not to answer |
| ○ | Data not collected |

| IF “YES” TO NON­CASH 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 prefers not to answer |
| ○ | 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 | | |
| ○ | Veterans Health Administration (VHA) | ○ | State Health Insurance for Adults | | |
| ○ | Other (specify): | ○ | Indian Health Services Program | | |

SPECIFIC YOUTH INFORMATION

PREGNANCY STATUS ​*[Adults and Head of Households]*

| ○ | No | | ○ | Client doesn’t know |
| --- | --- | --- | --- | --- |
| ○ | Yes | | ○ | Client prefers not to answer |
| ○ | Data not collected |
| IF “YES” for Pregnancy Status | | | | |
| Due Date | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ | | |

*If applicable:*



Signature of applicant stating all information is true and correct Date