CLARITY HMIS: KC- HHS-RHY 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:_____

Please ask the questions in the order below. It is best practice to complete program forms with adult household members separately.

PROGRAM STATUS DATE *[All Individuals/Client Households]*

		-			-				
Month			Day			Year			

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**.*	

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?	○	○	Client doesn't know
	○	○	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

A 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 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 Individuals/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

RHY SPECIFIC YOUTH INFORMATION

PREGNANCY STATUS *[Adults and Head of Households]*

○	No	o	Client doesn't know
○	Yes	o	Client prefers not to answer
		o	Data not collected
IF "YES" for Pregnancy Status			
Due Date	____/____/_____		

If applicable:

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