

Agency Name: _____



CLARITY HMIS: HUD - HOPWA PROJECT 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			

PHYSICAL DISABILITY *[All 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 Clients]*

☐	No	☐	Client doesn't know
☐	Yes	☐	Client prefers not to answer
		☐	Data not collected

CHRONIC HEALTH CONDITION *[All 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

HIV-AIDS *[All Clients]*

☐	No	☐	Client doesn't know
☐	Yes	☐	Client prefers not to answer
		☐	Data not collected

MENTAL HEALTH DISORDER *[All Clients]*

☐	No	☐	Client doesn't know		
☐	Yes	☐	Client prefers not to answer		
		☐	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?		☐	No	☐	Client doesn't know
		☐	Yes	☐	Client prefers not to answer
				☐	Data not collected

SUBSTANCE USE DISORDER *[All Clients]*

☐ No	☐ Client doesn't know	
☐ Alcohol use disorder	☐ Client prefers not to answer	
☐ Drug use disorder	☐ Data not collected	
☐ 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?	☐ No	☐ Client doesn't know
	☐ Yes	☐ Client prefers not to answer
		☐ Data not collected

SURVIVOR OF DOMESTIC VIOLENCE *[Head of Household and Adults]*

☐ No	☐ Client doesn't know	
☐ Yes	☐ Client prefers not to answer	
	☐ Data not collected	
IF "YES" TO SURVIVOR OF DOMESTIC VIOLENCE – SPECIFY WHEN EXPERIENCE OCCURRED		
☐ Within the past three months	☐ Client doesn't know	
☐ Three to six months ago (excluding six months exactly)	☐ Client prefers not to answer	
☐ Six months to one year ago (excluding one year exactly)	☐ Data not collected	
☐ One year ago or more		
Are you currently fleeing?	☐ 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 (<i>specify</i>):	
☐ 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 Child Care 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 & REASONS NOT COVERED BY NON-CHOSEN SELECTION(S)	
☐ MEDICAID	☐ Applied; decision pending ☐ Applied; client not eligible ☐ Client did not apply ☐ Insurance type N/A for this client ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
☐ MEDICARE	☐ Applied; decision pending ☐ Applied; client not eligible ☐ Client did not apply ☐ Insurance type N/A for this client ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
☐ State Children's Health Insurance (SCHIP)	☐ Applied; decision pending ☐ Applied; client not eligible ☐ Client did not apply ☐ Insurance type N/A for this client ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
☐ Veteran's Health Administration (VHA)	☐ Applied; decision pending ☐ Applied; client not eligible ☐ Client did not apply ☐ Insurance type N/A for this client ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
☐ Employer Provided Health Insurance	☐ Applied; decision pending ☐ Applied; client not eligible ☐ Client did not apply ☐ Insurance type N/A for this client ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

○	Health Insurance Obtained through COBRA	○	Applied; decision pending
		○	Applied; client not eligible
		○	Client did not apply
		○	Insurance type N/A for this client
		○	Client doesn't know
		○	Client prefers not to answer
		○	Data not collected
○	Private Pay Health Insurance	○	Applied; decision pending
		○	Applied; client not eligible
		○	Client did not apply
		○	Insurance type N/A for this client
		○	Client doesn't know
		○	Client prefers not to answer
		○	Data not collected
○	State Health Insurance for Adults	○	Applied; decision pending
		○	Applied; client not eligible
		○	Client did not apply
		○	Insurance type N/A for this client
		○	Client doesn't know
		○	Client prefers not to answer
		○	Data not collected
○	Indian Health Services Program	○	Applied; decision pending
		○	Applied; client not eligible
		○	Client did not apply
		○	Insurance type N/A for this client
		○	Client doesn't know
		○	Client prefers not to answer
		○	Data not collected
○	IEHP	○	Applied; decision pending
		○	Applied; client not eligible
		○	Client did not apply
		○	Insurance type N/A for this client
		○	Client doesn't know
		○	Client prefers not to answer
		○	Data not collected
○	Molina	○	Applied; decision pending
		○	Applied; client not eligible
		○	Client did not apply
		○	Insurance type N/A for this client
		○	Client doesn't know
		○	Client prefers not to answer
		○	Data not collected
○	Kaiser Permanente	○	Applied; decision pending
		○	Applied; client not eligible
		○	Client did not apply
		○	Insurance type N/A for this client
		○	Client doesn't know
		○	Client prefers not to answer

☐		☐	Data not collected
☐	Other Health Insurance (specify)		

IF “YES” TO HIV-AIDS:
Receiving AIDS Drug Assistance Program (ADAP)

☐	No	☐	Client doesn't know
☐	Yes	☐	Client prefers not to answer
		☐	Data not collected
IF “NO” TO RECEIVING AIDS DRUG ASSISTANCE PROGRAM (ADAP) – SPECIFY REASON			
☐	Applied; decision Pending	☐	Client doesn't know
☐	Applied; client not eligible	☐	Client prefers not to answer
☐	Client did not apply	☐	Data not collected
☐	Insurance type N/A for this client		

Receiving Ryan White-funded Medical or Dental Assistance

☐	No	☐	Client doesn't know
☐	Yes	☐	Client prefers not to answer
		☐	Data not collected
IF “NO” TO RECEIVING RYAN WHITE-FUNDED MEDICAL OR DENTAL ASSISTANCE – SPECIFY REASON			
☐	Applied; decision pending	☐	Client doesn't know
☐	Applied; client not eligible	☐	Client prefers not to answer
☐	Client did not apply	☐	Data not collected
☐	Insurance type N/A for this client		

T-cell (CD4) Count Available

☐	No	☐	Client doesn't know
☐	Yes	☐	Client prefers not to answer
		☐	Data not collected

T-cell Count (Integer between 0-1500): _____
How Was the Information Obtained?

☐	Medical Report
☐	Client report
☐	Other (specify)

Viral Load Information Available

☐	Not available	☐	Client doesn't know
☐	Available	☐	Client prefers not to answer
☐	Undetectable	☐	Data not collected

Count (Integer between 0-999999): _____
How Was the Information Obtained?

☐	Medical Report
☐	Client report

☐	Other (specify)
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Has the participant been prescribed anti-retroviral drugs?

☐	No	☐	Client doesn't know
☐	Yes	☐	Client prefers not to answer
		☐	Data not collected

IN PERMANENT HOUSING *[Permanent Housing Projects, for Head of Household]*

☐	No	☐	Yes
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IF "YES" TO PERMANENT HOUSING

Housing Move-In Date:*	____/____/____
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If client moved into permanent housing, make sure to update on the **enrollment screen.*

Signature of applicant stating all information is true and correct Date