

Agency Name: _____



CLARITY HMIS: 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.

--	--	--	--	--	--	--	--	--	--

PROGRAM STATUS DATE *[All Clients]*

Month

Day

Year

CURRENT NAME <i>[All Clients]</i>																N/A	
Last																	○
First																	
Middle																	
Suffix																	

DISABLING CONDITION *[All Clients]*

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

PHYSICAL DISABILITY *[All Clients]*

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

IF "YES" TO PHYSICAL DISABILITY – SPECIFY

Currently receiving services for physical disability																		○	No	○	Client doesn't know
																		○		○	Client refused

	<input type="radio"/>	Yes	<input type="radio"/>	Data not collected
Long-term physical disability	<input type="radio"/>	No	<input type="radio"/>	Client doesn't know
	<input type="radio"/>	Yes	<input type="radio"/>	Client refused
	<input type="radio"/>		<input type="radio"/>	Data not collected
Documentation of the disability and severity on file	<input type="radio"/>	No	<input type="radio"/>	Yes

DEVELOPMENTAL DISABILITY [All Clients]

<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 DEVELOPMENTAL DISABILITY – SPECIFY				
Currently receiving services for developmental disability	<input type="radio"/>	No	<input type="radio"/>	Client doesn't know
	<input type="radio"/>	Yes	<input type="radio"/>	Client refused
	<input type="radio"/>		<input type="radio"/>	Data not collected
Expected to substantially impair independence	<input type="radio"/>	No	<input type="radio"/>	Client doesn't know
	<input type="radio"/>	Yes	<input type="radio"/>	Client refused
	<input type="radio"/>		<input type="radio"/>	Data not collected
Documentation of the disability and severity on file	<input type="radio"/>	No	<input type="radio"/>	Yes

CHRONIC HEALTH CONDITION [All Clients]

<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			

Currently receiving services/treatment for this condition	<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	
Long-term chronic health condition	<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	
Documentation of the disability and severity on file	<input type="radio"/>	No	<input type="radio"/>	Yes

MENTAL HEALTH PROBLEM [All Clients]

<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 PROBLEM – SPECIFY				
Currently receiving services/treatment for this condition	<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	
Long-term mental health problem	<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	
Documentation of the disability and severity on file	<input type="radio"/>	No	<input type="radio"/>	Yes

SUBSTANCE ABUSE PROBLEM [All Clients]

<input type="radio"/>	No	<input type="radio"/>	Both alcohol and drug abuse
-----------------------	----	-----------------------	-----------------------------

○ Alcohol abuse	○	Client doesn't know		
	○	Client refused		
○ Drug abuse	○	Data not collected		
IF "ALCOHOL ABUSE" "DRUG ABUSE" OR "BOTH ALCOHOL AND DRUG ABUSE" – SPECIFY				
Currently receiving services/treatment for this condition	○	No	○	Client doesn't know
	○	Yes	○	Client refused
			○	Data not collected
Long-term substance abuse problem	○	No	○	Client doesn't know
	○	Yes	○	Client refused
			○	Data not collected
Documentation of the disability and severity on file	○	No	○	Yes

INCOME FROM ANY SOURCE [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		
		<input type="radio"/>	Data not collected		
IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY					
Income Source		Amount	Income Source	Amount	
<input type="radio"/>	Earned Income		<input type="radio"/>	TANF (Temporary Assistance for Needy Families)	
<input type="radio"/>	Unemployment Insurance		<input type="radio"/>	General Assistance (GA)	
<input type="radio"/>	Supplemental Security Income (SSI)		<input type="radio"/>	Retirement Income from Social Security	
<input type="radio"/>	Social Security Disability Income (SSDI)		<input type="radio"/>	Pension or retirement income from former job	
<input type="radio"/>	VA Service Connected Disability Compensation		<input type="radio"/>	Child support	
<input type="radio"/>	VA NonService Connect Disability Pensioned		<input type="radio"/>	Alimony and other spousal support	
<input type="radio"/>	Private disability insurance		<input type="radio"/>	Other source	
<input type="radio"/>	Worker's Compensation		Specify Other"		
Total monthly amount:					

RECEIVING NONCASH BENEFITS *[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
		<input type="radio"/>	Data not collected
IF "YES" TO NONCASH BENEFITS – INDICATE ALL SOURCES THAT APPLY			
<input type="radio"/>	SNAP	<input type="radio"/>	Other TANF Benefit
<input type="radio"/>	WIC	<input type="radio"/>	Section 8
<input type="radio"/>	TANF Childcare	<input type="radio"/>	Temporary Rental Assistance
<input type="radio"/>	TANF Transportation	<input type="radio"/>	Other (Specify):

HEALTH INSURANCE *[All Clients]*

<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 HEALTH INSURANCE HEALTH INSURANCE COVERAGE DETAILS			
<input type="radio"/>	MEDICAID	<input type="radio"/>	Employer Provided
<input type="radio"/>	MEDICARE	<input type="radio"/>	Obtained through COBRA
<input type="radio"/>	SCHIP	<input type="radio"/>	Private Pay Health Insurance
<input type="radio"/>	VA Medical	<input type="radio"/>	State Health Insurance for Adults
<input type="radio"/>	Other (specify)	<input type="radio"/>	Indian Health Services Program

RHY SPECIFIC YOUTH INFORMATION
PREGNANCY STATUS *[All Female: HoH, Adults and Unaccompanied Youth]*

<input type="radio"/>	No	<input type="radio"/>	Client doesn't know
<input type="radio"/>		<input type="radio"/>	Client refused

<input type="radio"/>	Yes	<input type="radio"/>	Data not collected
IF "YES" for Pregnancy Status			
Due Date	____/____/____		

Signature of applicant stating all information is true and correct Date