Community Alliance FOR THE HOMELESS

HMIS COC/ESG Program Status Form

Community Alliance for the Homeless -HMIS- Memphis, TN 38112 -Phone: 901.527.1302

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

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**.*

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	◊	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

DOMESTIC VIOLENCE VICTIM/SURVIVOR *[Head of Household and Adults]*

◊	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

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 *(specify):*	
◊	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 HEALTH INSURANCE COVERAGE DETAILS

◊	MEDICAID	◊	Employer Provided Health Insurance
◊	MEDICARE	◊	Insurance Obtained through COBRA
◊	State Children's Health Insurance (SCHIP)	◊	Private Pay Health Insurance
◊	Veteran's Health Administration (VHA)	◊	State Health Insurance for Adults
◊	Other (specify):	◊	Indian Health Services Program

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