Community Alliance
FOR THE HOMELESS

Youth Homelessness Demonstration Project 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			

CLIENT LOCATION *[only if multiple CoC's]* _________________________

Disabling Conditions and Barriers

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 doesn't know
			○	Data not collected

DEVELOPMENTAL DISABILITY *[All Clients]*

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

CHRONIC HEALTH CONDITION *[All Clients]*

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

CLARITY HUMAN SERVICES

MENTAL HEALTH DISORDER *[All Clients]*

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

SUBSTANCE USE DISORDER *[All Clients]*

○	No	○	Both alcohol and drug use disorders
○	Alcohol use disorder	○	Client doesn't know
		○	Client doesn't know
○	Drug use disorder	○	Data not collected

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 doesn't know
			○	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			
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 doesn't know
		○	Data not collected
IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY			

CLARITY HUMAN SERVICES

	Income Source	Amount		Income Source	Amount
☐	Earned Income		☐	TANF (Temporary Assist for Needy Families)	
☐	Unemployment Insurance		☐	General Assistance (GA)	
☐	Supplemental Security Income (SSI)		☐	Retirement Income from Social Security	
☐	Social Security Disability Insurance (SSDI)		☐	Pension or retirement income from 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 doesn't know
		☐	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 Clients]*

☐	No	☐	Client doesn't know
☐	Yes	☐	Client doesn't know
		☐	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

PREGNANCY STATUS *[Adults and Head of Households]*

☐	No	☐	Client doesn't know
☐	Yes	☐	Client doesn't know
		☐	Data not collected
IF "YES" for Pregnancy Status			

CLARITY HUMAN SERVICES

Due Date	___/____/__________

____

Signature of applicant stating all information is true and correct   Date