

DHHS SUBSIDY SUPPORT SERVICES FORM

Instructions: Please complete the following questions and table for each household member (adults and children). This form should be completed at the time of **Move In** and **Annual Review**.

1. **Date Completed:** _____

2. **Household Member Name:** _____

3. **Are you the Head of Household?** Yes No

3a. **If No, Name of Head of Household:** _____

4. **Grant Name:** _____

5. **Do you have a Mental Health Condition?**

- Yes, is of long and indefinite duration and **substantially impairs** ability to live independently
- Yes, is of long and indefinite duration and **does not substantially impair** ability to live independently
- No

6. **Do you now, or have you had in the past, an Alcohol Abuse Problem?**

- Yes, I currently have an alcohol abuse problem of long and indefinite duration that substantially impairs my ability to live independently.
- Yes, I have had an alcohol abuse problem in the past, but not currently.
- No

7. **Do you now, or have you had in the past, a Drug Abuse Problem?**

- Yes, I currently have a drug abuse problem of long and indefinite duration that substantially impairs my ability to live independently.
- Yes, I have had a drug abuse problem in the past, but not currently.
- No

8. **Do you have HIV/AIDS?** Yes No Unknown Refused

9. **Do you have a Developmental Disability?** Yes No

10. **Do you have a Physical Disability?** Yes No

11. **Do you have a Chronic Health Condition?** Yes No

(Example: heart disease, severe asthma, diabetes, arthritis-related conditions, traumatic brain injury, post-traumatic distress syndrome, dementia, severe headache/migraine, cancer, chronic bronchitis, liver condition, stroke, emphysema, etc.)

12. **Are you currently receiving services and/or treatment for any of the following conditions?**

- None
- Substance abuse; Alcohol and/or Drug abuse (Case Management, Treatment Clinics, Support Groups, etc.)
- Developmental disability (Case Management, Life Skills, etc.)
- HIV/AIDS (Case Management, Medical Treatment, Support Groups, etc.)
- Physical disability (Medical Treatment, Physical Therapy, Occupational Therapy, etc.)
- Mental health condition (Case Management, Life Skills, Therapy, Peer Support, Psychiatry, etc.)
- Chronic Health Condition (Medical Treatment, Case Management, Physical Therapy, Social Support, etc.)
- Other; Specify: _____

13. **Are you currently looking for employment or increased employment hours?** Yes No