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

Revised 5/11/2012