Agency Name: \_\_\_\_\_



## San Francisco ONE System: HHS-PATH STATUS ASSESSMENT FORM

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]											
	INOULOI		OO DATE	. [/~ii								
	Month		Day		Yea	ar						
	o.i.i. Day .oa.											
	CLIENT L	OCAT	ION [only	if multip	ole CoC's]							
PA	TH STATUS [If	not at	intake]									
				0	No							
Clie	ent Became Enro	olled in	PATH	0	Yes							
Dat	e of Status Det	ermin	ation	•	/	/_						
IF "	'NO" TO ENRO	LLED	IN PATH									
D	N - 4 F U -	_1		0	Client wa	as fou	ınd in	eligible	for I	PATH		
Rea	ason Not Enrolle	ed		0	Client wa	as no	t enro	olled for	othe	er reason(s)		
C	ONNECTION W	ITH SC	DAR [Head	ds of H	ouseholds	and	Adult	s]		1		
0	No								0	Client doesn't know		
0	Yes							-	0			
									0	Data not collected		
DIS	SABLING CONI	OITION	I [All Clien	ts]								
0	No								0	Client doesn't know		
	Voc								0	Client refused		
0	Yes								0	Data not collected		
PH	YSICAL DISAB	ILITY	[All Client:	s]								
0	No									Client doesn't know		
(	Yes									<ul> <li>Client refused</li> </ul>		
0	<ul> <li>Yes</li> <li>Data not collected</li> </ul>											
IF	"YES" TO PHY	SICAL	DISABIL	ITY – S	PECIFY			1				
Ev	Expected to be of long-continued and indefinite duration					No		<ul> <li>Client doesn't know</li> </ul>				
	d substantially ir	_					0	Yes		<ul> <li>Client refused</li> </ul>		
J 1.		T 9			, <b>y</b>	-	Ŭ	. 50		<ul> <li>Data not collected</li> </ul>		



**DEVELOPMENTAL DISABILITY** [All Clients]

0	No			0	Client doesn't know	
	· Yes			0	Client refused	
0				0	Data not collected	
IF '	IF "YES" TO DEVELOPMENTAL DISABILITY – SPECIFY					
			No	0	Client doesn't know	
Expected to substantially impair ability to live independently?			Yes	0	Client refused	
IIIU	spendently!		168	0	Data not collected	

**CHRONIC HEALTH CONDITION** [All Clients]

0	No			0	Client doesn't know
	· Yes			0	Client refused
0				0	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?   O No  Yes		No	0	Client doesn't know	
		0	Client refused		
and	a substantially impairs ability to live independently!		Yes	0	Data not collected

**HIV-AIDS** [All Clients]

0	o No			0	Client doesn't know	
				0	Client refused	
O	o Yes				Data not collected	
IF '	IF "YES" TO HIV-AIDS – SPECIFY					
	_		No	0	Client doesn't know	
	Expected to substantially impair ability to live independently?		Vaa	0	Client refused	
ind	ependently :		Yes	0	Data not collected	

MENTAL HEALTH PROBLEM [All Clients]

0	o No				Client doesn't know	
	W <sub>2</sub> -				Client refused	
0	Yes	0	Data not collected			
IF '	IF "YES" TO MENTAL HEALTH CONDITION – SPECIFY					
	o No				Client doesn't know	
	Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?  Yes			0	Client refused	
and				0	Data not collected	



**SUBSTANCE ABUSE PROBLEM** [All Clients]

	obbit ittobilit ittobilit [rui ononto]						
0	No	0	Both alcohol and drug abuse				
Alaskal skups		0	Client doesn't know				
0	Alcohol abuse		Client refu	Client refused			
0	○ Drug abuse ○ Data not collected				cted		
IF "ALCOHOL ABUSE" "DRUG ABUSE" OR "BOTH ALCOHOL AND DRUG ABUSE" – SPECIFY							
			No	0	Client doesn't know		
	pected to be of long-continued and indefinite duration displays ability to live independently?		Yes	0	Client refused		
and		0	162	0	Data not collected		

## **INCOME FROM ANY SOURCE** [Head of Household and Adults]

0	No	0	Client doesn't know
	Yes	0	Client refused
O		0	Data not collected

IF "	YES" TO INCOME FROM ANY SOURCE	1				_ <u>Y</u> Amount		
	Income Source	Amount		Inco	Income Source			
0	Alimony and other spousal support		0	Child sup				
0	Pension or retirement income from former job		0	Earned I				
0	Retirement Income from Social Security		0	CAAP				
0	Social Security Disability Insurance (SSDI)		0	Private o				
0	Supplemental Security Income (SSI)		0	Unemplo				
0	CalWORKs		0	Worker's	Compensation			
0	VA Service Connected Disability Compensation		0	Other so				
0	<ul> <li>VA NonService Connected Disability Pension</li> </ul>		Oth (spe	er ecify):				
Tota	ıl monthly amount:							



## **RECEIVING NON-CASH BENEFITS** [Head of Household and Adults]

0	No			0	Client doesn't know
	Voc			0	Client refused
O	○ Yes			0	Data not collected
IF "YI	IF "YES" TO NON-CASH BENEFITS – INDICATE ALL SOURCES THAT APPLY				
0	CalFresh	0	CalWORK	(s Cl	nildcare Services
	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	0	CalWORK Services	(s Tr	ansportation
0	Other (specify):	0	Other Cal	WOF	RKs-funded services

**COVERED BY HEALTH INSURANCE** [All Clients]

				_	
0	No			Client doesn't know	
	V			Client refused	
0	Yes	0	Data not collected		
IF "	YES" TO HEALTH INSURANCE - HEALTH INSURAN	COVERAGE D	ETAILS		
0	Medi-Cal	0	Employer Pr	ovided Health	
	Weur-oai		Insurance		
0	MEDICARE		Insurance Obtained through		
	WESTO, IKE		COBRA		
0	State Children's Health Insurance (SCHIP)	0	Private Pay I	Health Insurance	
0	Veteran's Administration (VA) Medical Services	0	State Health Insurance for Adults		
0	Other (specify):	0	Indian Health	n Services Program	

Signature of applicant stating all information is true and correct Date