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]*

		-			-				

Month **Day** **Year**

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

PATH STATUS *[If not at intake]*

Client Became Enrolled in PATH	○	No
	○	Yes
Date of Status Determination		____/____/_____
IF "NO" TO ENROLLED IN PATH		
Reason Not Enrolled	○	Client was found ineligible for PATH
	○	Client was not enrolled for other reason(s)

CONNECTION WITH SOAR *[Heads of Households and Adults]*

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

DISABLING CONDITION *[All Clients]*

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

PHYSICAL DISABILITY *[All Clients]*

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

DEVELOPMENTAL DISABILITY *[All Clients]*

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

IF "YES" TO DEVELOPMENTAL DISABILITY – SPECIFY

Expected to substantially impair ability to live independently?	○	No	○	Client doesn't know
	○	Yes	○	Client refused
			○	Data not collected

CHRONIC HEALTH CONDITION *[All Clients]*

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

HIV-AIDS *[All Clients]*

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

IF "YES" TO HIV-AIDS – SPECIFY

Expected to substantially impair ability to live independently?	○	No	○	Client doesn't know
	○	Yes	○	Client refused
			○	Data not collected

MENTAL HEALTH PROBLEM *[All Clients]*

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

IF "YES" TO MENTAL 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 refused
			○	Data not collected

SUBSTANCE ABUSE PROBLEM *[All Clients]*

○	No	○	Both alcohol and drug abuse
○	Alcohol abuse	○	Client doesn't know
		○	Client refused
○	Drug abuse	○	Data not collected

IF "ALCOHOL ABUSE" "DRUG ABUSE" OR "BOTH ALCOHOL AND DRUG ABUSE" – SPECIFY

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	○	No	○	Client doesn't know
	○	Yes	○	Client refused
			○	Data not collected

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

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

IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY

	Income Source	Amount		Income Source	Amount
○	Alimony and other spousal support		○	Child support	
○	Pension or retirement income from former job		○	Earned Income	
○	Retirement Income from Social Security		○	CAAP	
○	Social Security Disability Insurance (SSDI)		○	Private disability insurance	
○	Supplemental Security Income (SSI)		○	Unemployment Insurance	
○	CalWORKs		○	Worker's Compensation	
○	VA Service Connected Disability Compensation		○	Other source	
○	VA Non--Service Connected Disability Pension		Other (specify):		
Total monthly amount:					

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

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

IF "YES" TO NON-CASH BENEFITS – INDICATE ALL SOURCES THAT APPLY			
○	CalFresh	○	CalWORKs Childcare Services
○	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	○	CalWORKs Transportation Services
○	Other (specify):	○	Other CalWORKs-funded services

COVERED BY HEALTH INSURANCE *[All Clients]*

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

IF "YES" TO HEALTH INSURANCE - HEALTH INSURANCE COVERAGE DETAILS			
○	Medi-Cal	○	Employer Provided Health Insurance
○	MEDICARE	○	Insurance Obtained through COBRA
○	State Children's Health Insurance (SCHIP)	○	Private Pay Health Insurance
○	Veteran's Administration (VA) Medical Services	○	State Health Insurance for Adults
○	Other (specify):	○	Indian Health Services Program

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