Agency Name:

_____

CLARITY HMIS: 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]* _____

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

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

PATH STATUS *[If not at intake]*

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

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?	○	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

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?	○	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

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

DOMESTIC VIOLENCE *[All Clients]*

Domestic Violence Victim/Survivor	○	No
	○	Yes
If "YES" to DOMESTIC VIOLENCE VICTIM/ SURVIVOR- COMPLETE		
LAST OCCURRENCE		___/____/_____
Are you currently fleeing?	○	Yes
	○	No
	○	Client doesn't know
	○	Client refused
	○	Data not collected

MONTHLY INCOME AND SOURCES *[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
○	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	
○	Worker's Compensation		○	Other income source	
Total monthly income for Individuals:					

RECEIVING NONCASH BENEFITS *[Head of Household and Adults]*

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

IF "YES" TO NONCASH 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 refused
		○	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 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