**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 DayYear**

**CONNECTION WITH SOAR** ​*[Head of Household and Adults]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  | | ○ | 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 prefers not to answer |
|  | | | | ○ | 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 prefers not to answer |
|  |  | ○ | Data not collected |

**DEVELOPMENTAL DISABILITY** ​*[All Clients]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  | | ○ | Data not collected |

**CHRONIC HEALTH CONDITION** ​*[All Clients]*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ○ | No | | | ○ | Client doesn’t know |
| ○ | Yes | | | ○ | Client prefers not to answer |
|  | | | | ○ | 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 prefers not to answer |
|  |  | ○ | Data not collected |

**HIV-AIDS** ​*[All Clients]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  | | ○ | Data not collected |

**MENTAL HEALTH DISORDER** ​*[All Clients]*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ○ | No | | | ○ | Client doesn’t know |
| ○ | Yes | | | ○ | Client prefers not to answer |
|  | | | | ○ | Data not collected |
| IF “YES” TO MENTAL HEALTH DISORDER – SPECIFY | | | | | |
| Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? | | ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  |  | ○ | Data not collected |

**SUBSTANCE USE DISORDER** ​*[All Clients]*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ○ | | No | | | ○ | Client doesn’t know |
| ○ | | Alcohol use disorder | | | ○ | Client prefers not to answer |
| ○ | Drug use disorder | | | | ○ | Data not collected |
| ○ | Both alcohol and drug use disorders | | | |  | |
| IF “ALCOHOL USE DISORDER” “DRUG USE DISORDER” OR “BOTH ALCOHOL AND DRUG USE DISORDERS” – SPECIFY | | | | | | |
| Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? | | | ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  |  | ○ | Data not collected |

**SURVIVOR OF DOMESTIC VIOLENCE** *​[Head of Household and Adults]*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ○ | No | | | ○ | Client doesn’t know |
| ○ | Yes | | | ○ | Client prefers not to answer |
|  | | | | ○ | Data not collected |
| IF “YES” TO SURVIVOR OF DOMESTIC VIOLENCE – SPECIFY WHEN EXPERIENCE OCCURRED | | | | | |
| ○ | Within the past three months | | | ○ | Client doesn’t know |
| ○ | Three to six months ago (excluding six months exactly) | | | ○ | Client prefers not to answer |
| ○ | Six months to one year ago (excluding one year exactly) | | | ○ | Data not collected |
| ○ | One year ago or more | | |  | |
| Are you currently fleeing? | | ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  |  | ○ | Data not collected |

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

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  | | ○ | Data not collected |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| IF “YES” TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY | | | | | |
| Income Source | | Amount | Income Source | | Amount |
| ○ | Earned Income |  | ○ | Temporary Assistance for Needy Families (TANF) |  |
| ○ | Unemployment Insurance |  | ○ | General Assistance (GA) |  |
| ○ | Supplemental Security Income (SSI) |  | ○ | Retirement income from Social Security |  |
| ○ | Social Security Disability Insurance (SSDI) |  | ○ | Pension or retirement income from a 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 *(specify):* |  |
| ○ | Worker’s Compensation |  |
| Total Monthly Income for Individual: | | | | | |

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

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  | | ○ | Data not collected |
| IF “YES” TO NON-CASH BENEFITS – INDICATE ALL SOURCES THAT APPLY | | | |
| ○ | Supplemental Nutrition Assistance Program (SNAP) | ○ | TANF Child Care 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 prefers not to answer |
|  | | ○ | Data not collected |
| IF “YES” TO HEALTH INSURANCE – HEALTH INSURANCE COVERAGE DETAILS | | | |
| ○ | MEDICAID | ○ | Employer Provided Health Insurance |
| ○ | MEDICARE | ○ | Health Insurance Obtained Through COBRA |
| ○ | State Children’s Health Insurance (SCHIP) | ○ | Private Pay Health Insurance |
| ○ | Veteran’s Health Administration (VHA) | ○ | State Health Insurance for Adults |
| ○ | Other (specify): | ○ | Indian Health Services Program |
| ○ | Anthem | ○ | Molina |
| ○ | HPN | ○ | SilverSummit |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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