

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]*

|                           |   |
|---------------------------|---|
| <input type="radio"/> No  | <input type="radio"/> Client doesn't know |
| <input type="radio"/> Yes | <input type="radio"/> Client refused      |
|                           | <input type="radio"/> Data not collected  |

**PATH STATUS** *[If not at intake]*

|                                    |                           |   |
|------------------------------------|---------------------------|---|
| Date of Status Determination       |                           | ____/____/____                              |
| Client Became Enrolled in PATH     | <input type="radio"/> No  |   |
|                                    | <input type="radio"/> Yes |   |
| <b>IF "NO" TO ENROLLED IN PATH</b> |                           |   |
| Reason Not Enrolled                | <input type="radio"/>     | Client was found ineligible for PATH        |
|                                    | <input type="radio"/>     | Client was not enrolled for other reason(s) |
|                                    | <input type="radio"/>     | Unable to locate client                     |

**PHYSICAL DISABILITY** *[All Clients]*

|   |   |   |
|---|---|---|
| <input type="radio"/> No                                  | <input type="radio"/> Client doesn't know |   |
| <input type="radio"/> Yes                                 | <input type="radio"/> Client refused      |   |
|   | <input type="radio"/> Data not collected  |   |
| <b>IF "YES" TO PHYSICAL DISABILITY – SPECIFY</b>          |   |   |
| Expected to be of long-continued and indefinite duration? | <input type="radio"/> No                  | <input type="radio"/> Client doesn't know |
|   | <input type="radio"/> Yes                 | <input type="radio"/> Client refused      |
|   |   | <input type="radio"/> Data not collected  |

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

|                           |   |
|---------------------------|---|
| <input type="radio"/> No  | <input type="radio"/> Client doesn't know |
| <input type="radio"/> Yes | <input type="radio"/> Client refused      |
|                           | <input type="radio"/> Data not collected  |

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

|                           |   |
|---------------------------|---|
| <input type="radio"/> No  | <input type="radio"/> Client doesn't know |
| <input type="radio"/> Yes | <input type="radio"/> Client refused      |
|                           | <input type="radio"/> Data not collected  |

**IF "YES" TO CHRONIC HEALTH CONDITION – SPECIFY**

|   |                           |  |
|---|---------------------------|--|
| Expected to be of long-continued and indefinite duration? | <input type="radio"/> No  | <input type="radio"/> Client doesn't know  |
|   | <input type="radio"/> Yes | <input type="radio"/> Client refused<br><input type="radio"/> Data not collected |

**HIV-AIDS** *[All Clients]*

|                           |   |
|---------------------------|---|
| <input type="radio"/> No  | <input type="radio"/> Client doesn't know |
| <input type="radio"/> Yes | <input type="radio"/> Client refused      |
|                           | <input type="radio"/> Data not collected  |

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

|                           |   |
|---------------------------|---|
| <input type="radio"/> No  | <input type="radio"/> Client doesn't know |
| <input type="radio"/> Yes | <input type="radio"/> Client refused      |
|                           | <input type="radio"/> Data not collected  |

**IF "YES" TO MENTAL HEALTH DISORDER- SPECIFY**

|   |                           |  |
|---|---------------------------|--|
| Expected to be of long-continued and indefinite duration? | <input type="radio"/> No  | <input type="radio"/> Client doesn't know  |
|   | <input type="radio"/> Yes | <input type="radio"/> Client refused<br><input type="radio"/> Data not collected |

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

|  |   |
|--|---|
| <input type="radio"/> No                   | <input type="radio"/> Both alcohol and drug use disorders |
| <input type="radio"/> Alcohol use disorder | <input type="radio"/> Client doesn't know                 |
|  | <input type="radio"/> Client refused                      |
| <input type="radio"/> Drug use disorder    | <input type="radio"/> Data not collected                  |

**IF "ALCOHOL USE DISORDER" "DRUG USE DISORDER" OR "BOTH ALCOHOL AND DRUG USE DISORDERS" – SPECIFY**

|   |                           |  |
|---|---------------------------|--|
| Expected to be of long-continued and indefinite duration? | <input type="radio"/> No  | <input type="radio"/> Client doesn't know  |
|   | <input type="radio"/> Yes | <input type="radio"/> Client refused<br><input type="radio"/> Data not collected |

**DOMESTIC VIOLENCE** *[All Clients]*

|                                   |                           |
|-----------------------------------|---------------------------|
| Domestic Violence Victim/Survivor | <input type="radio"/> No  |
|                                   | <input type="radio"/> Yes |

**If "YES" to DOMESTIC VIOLENCE VICTIM/ SURVIVOR- COMPLETE**

|                            |   |
|----------------------------|---|
| <b>LAST OCCURRENCE</b>     | ____/____/____                            |
| Are you currently fleeing? | <input type="radio"/> Yes                 |
|                            | <input type="radio"/> No                  |
|                            | <input type="radio"/> Client doesn't know |
|                            | <input type="radio"/> Client refused      |
|                            | <input type="radio"/> Data not collected  |

**MONTHLY INCOME AND SOURCES** *[Head of Household and Adults]*

|   |   |  |        |
|---|---|--|--------|
| <input type="radio"/> No  | <input type="radio"/> Client doesn't know |  |        |
| <input type="radio"/> Yes   | <input type="radio"/> Client refused      |  |        |
|   | <input type="radio"/> Data not collected  |  |        |
| <b>IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY</b> |   |  |        |
| Income Source   | Amount                                    | Income Source  | Amount |
| <input type="radio"/> Earned Income   |   | <input type="radio"/> TANF (Temporary Assist for Needy Families)   |        |
| <input type="radio"/> Unemployment Insurance                                |   | <input type="radio"/> General Assistance (GA)                      |        |
| <input type="radio"/> Supplemental Security Income (SSI)                    |   | <input type="radio"/> Retirement income from Social Security       |        |
| <input type="radio"/> Social Security Disability Insurance (SSDI)           |   | <input type="radio"/> Pension or retirement income from former job |        |
| <input type="radio"/> VA Service-Connected Disability Compensation          |   | <input type="radio"/> Child support                                |        |
| <input type="radio"/> VA Non-Service Connected Disability Pension           |   | <input type="radio"/> Alimony and other spousal support            |        |
| <input type="radio"/> Private disability insurance                          |   | <input type="radio"/> Other income source<br><i>(specify):</i>     |        |
| <input type="radio"/> Worker's Compensation                                 |   |  |        |
| <b>Total monthly income for Individuals:</b>                                |   |  |        |

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

|   |  |
|---|--|
| <input type="radio"/> No  | <input type="radio"/> Client doesn't know          |
| <input type="radio"/> Yes   | <input type="radio"/> Client refused               |
|   | <input type="radio"/> Data not collected           |
| <b>IF "YES" TO NON-CASH BENEFITS – INDICATE ALL SOURCES THAT APPLY</b>                              |  |
| <input type="radio"/> Supplemental Nutrition Assistance Program (SNAP)                              | <input type="radio"/> TANF Child Care Services     |
| <input type="radio"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) | <input type="radio"/> TANF Transportation Services |
| <input type="radio"/> Other (specify):  | <input type="radio"/> Other TANF-funded services   |

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

|   |  |
|---|--|
| <input type="radio"/> No  | <input type="radio"/> Client doesn't know                |
| <input type="radio"/> Yes   | <input type="radio"/> Client refused                     |
|   | <input type="radio"/> Data not collected                 |
| <b>IF "YES" TO HEALTH INSURANCE - HEALTH INSURANCE COVERAGE DETAILS</b> |  |
| <input type="radio"/> MEDICAID  | <input type="radio"/> Employer Provided Health Insurance |
| <input type="radio"/> MEDICARE  | <input type="radio"/> Insurance Obtained through COBRA   |
| <input type="radio"/> State Children's Health Insurance (SCHIP)         | <input type="radio"/> Private Pay Health Insurance       |
| <input type="radio"/> Veteran's Administration (VA) Medical Services    | <input type="radio"/> State Health Insurance for Adults  |
| <input type="radio"/> Other (specify):                                  | <input type="radio"/> Indian Health Services Program     |

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