

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]* _____

PATH STATUS *[If not at intake]*

Client Became Enrolled in PATH	<input type="radio"/>	No	<input type="radio"/>	Yes
Date of Status Determination		___/___/_____		
IF "NO" TO ENROLLED IN PATH				
Reason Not Enrolled	<input type="radio"/>	Client was found ineligible for PATH		
	<input type="radio"/>	Client was not enrolled for other reason(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

DISABLING 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

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

IF "YES" TO PHYSICAL DISABILITY – SPECIFY

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	<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

IF "YES" TO DEVELOPMENTAL DISABILITY – SPECIFY

Expected to substantially impair ability to live independently?	<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 and substantially impairs ability to live independently?	<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

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	
IF "YES" TO HIV-AIDS – SPECIFY				
Expected to substantially impair ability to live independently?	<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 PROBLEM *[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 CONDITION – SPECIFY				
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	<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

SUBSTANCE ABUSE PROBLEM *[All Clients]*

<input type="radio"/>	No	<input type="radio"/>	Both alcohol and drug abuse	
<input type="radio"/>	Alcohol abuse	<input type="radio"/>	Client doesn't know	
		<input type="radio"/>	Client refused	
<input type="radio"/>	Drug abuse	<input type="radio"/>	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?	<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

INCOME FROM ANY SOURCE *[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

IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY					
Income Source		Amount	Income Source		Amount
<input type="checkbox"/>	Alimony and other spousal support		<input type="checkbox"/>	Child support	
<input type="checkbox"/>	Pension or retirement income from former job		<input type="checkbox"/>	Earned Income	
<input type="checkbox"/>	Retirement Income from Social Security		<input type="checkbox"/>	General Assistance (GA)	
<input type="checkbox"/>	Social Security Disability Insurance (SSDI)		<input type="checkbox"/>	Private disability insurance	
<input type="checkbox"/>	Supplemental Security Income (SSI)		<input type="checkbox"/>	Unemployment Insurance	
<input type="checkbox"/>	TANF (Temporary Assist for Needy Families)		<input type="checkbox"/>	Worker's Compensation	
<input type="checkbox"/>	VA Service Connected Disability Compensation		<input type="checkbox"/>	Other source	
<input type="checkbox"/>	VA Non--Service Connected Disability Pension		Other (specify):		
Total monthly amount:					

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

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

IF "YES" TO NON-CASH BENEFITS – INDICATE ALL SOURCES THAT APPLY

<input type="checkbox"/>	Supplemental Nutrition Assistance Program (SNAP)	<input type="checkbox"/>	TANF Childcare Services
<input type="checkbox"/>	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	<input type="checkbox"/>	TANF Transportation Services
<input type="checkbox"/>	Other (specify):	<input type="checkbox"/>	Other TANF-funded services

COVERED BY HEALTH INSURANCE [*All Clients*]

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

IF "YES" TO HEALTH INSURANCE - HEALTH INSURANCE COVERAGE DETAILS

<input type="checkbox"/>	MEDICAID	<input type="checkbox"/>	Employer Provided Health Insurance
<input type="checkbox"/>	MEDICARE	<input type="checkbox"/>	Insurance Obtained through COBRA
<input type="checkbox"/>	State Children's Health Insurance (SCHIP)	<input type="checkbox"/>	Private Pay Health Insurance
<input type="checkbox"/>	Veteran's Administration (VA) Medical Services	<input type="checkbox"/>	State Health Insurance for Adults
<input type="checkbox"/>	Other (specify):	<input type="checkbox"/>	Indian Health Services Program

Signature of applicant stating all information is true and correct Date