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 DISORDER *[All Clients]*

○	No		○	Client doesn't know
○	Yes		○	Client refused
			○	Data not collected
IF "YES" TO MENTAL HEALTH DISORDER– SPECIFY				
Expected to be of long-continued and indefinite duration?	○ No		○	Client doesn't know
	○ Yes		○	Client refused
			○	Data not collected

SUBSTANCE USE DISORDER *[All Clients]*

○	No	○	Both alcohol and drug use disorders
○	Alcohol use disorder	○	Client doesn't know
		○	Client refused
○	Drug use disorder	○	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?	○ 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

CLARITY HUMAN SERVICES

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 *(specify):*	
○	Worker's Compensation				
Total monthly income for Individuals:					

RECEIVING NON CASH 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 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 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

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Signature of applicant stating all information is true and correct Date