

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	___/___/_____		
<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)	

**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

**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="radio"/> Alimony and other spousal support		<input type="radio"/> Child support	
<input type="radio"/> Pension or retirement income from former job		<input type="radio"/> Earned Income	
<input type="radio"/> Retirement Income from Social Security		<input type="radio"/> General Assistance (GA)	
<input type="radio"/> Social Security Disability Insurance (SSDI)		<input type="radio"/> Private disability insurance	
<input type="radio"/> Supplemental Security Income (SSI)		<input type="radio"/> Unemployment Insurance	
<input type="radio"/> TANF (Temporary Assist for Needy Families)		<input type="radio"/> Worker's Compensation	
<input type="radio"/> VA Service Connected Disability Compensation		<input type="radio"/> Other source	
<input type="radio"/> VA Non--Service Connected Disability Pension		Other (specify):	
<b>Total monthly amount:</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 Childcare 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**