



# COHMIS

## PATH Intake Form

<b>SOCIAL SECURITY NUMBER (SSN)</b>									
<b>QUALITY OF SSN</b>		<input type="checkbox"/> Full SSN reported <input type="checkbox"/> Approximate/partial SSN reported				<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected			
<b>CLIENT NAME</b>									
Last:									
First:									
Middle:						Suffix:			
<b>QUALITY OF NAME</b>		<input type="checkbox"/> Full name reported <input type="checkbox"/> Partial, street name, or code name reported				<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected			
<b>DATE OF BIRTH (DOB)</b> (MM/DD/YYYY)									
<b>QUALITY OF DOB</b>		<input type="checkbox"/> Full DOB reported <input type="checkbox"/> Approximate/partial DOB reported				<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected			
<b>GENDER</b>									
<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Trans Female (MTF or Male to Female) <input type="checkbox"/> Trans Male (FTM or Female to Male) <input type="checkbox"/> Gender Non-Conforming (not exclusively male or female)				<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected			
<b>RACE</b>									
<input type="checkbox"/> White <input type="checkbox"/> Black or African American		<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian				<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected			
<b>ETHNICITY</b>									
<input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Hispanic/Latino		<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected							
<b>VETERAN STATUS</b>									
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected							
<b>RELATIONSHIP TO HEAD OF HOUSEHOLD</b>									
<input type="checkbox"/> Self (head of household) <input type="checkbox"/> Head of household's child <input type="checkbox"/> Head of household's spouse or partner		<input type="checkbox"/> Head of household's other relation member <input type="checkbox"/> Other: non-relation member							

<b>PROJECT NAME</b>															
<b>PROJECT START DATE</b> (MM/DD/YYYY)															
<b>Has the client ever experienced homelessness before?</b>	<input type="checkbox"/> No			<input type="checkbox"/> Client doesn't know			<input type="checkbox"/> Data not collected			<input type="checkbox"/> Yes			<input type="checkbox"/> Client refused		
<b>PRIOR LIVING SITUATION</b> (Where did the client sleep the night before entering this project?) (PICK ONLY 1)															
<b>HOMELESS SITUATION</b>															
<input type="checkbox"/> Place not meant for human habitation (vehicle, anywhere outside) <input type="checkbox"/> Emergency shelter, including hotel or motel paid for w/ emergency shelter voucher or RHY-funded host home <input type="checkbox"/> Safe Haven															
<b>INSTITUTIONAL SITUATION</b>															
<input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail, prison or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center															
<b>TRANSITIONAL &amp; PERMANENT HOUSING SITUATION</b>															
<input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Staying or living in a friend's room, apartment, or house <input type="checkbox"/> Staying or living in a family member's room, apartment, or house <input type="checkbox"/> Rental by client, with GPD TIP subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons <input type="checkbox"/> Rental by client, with RRH or equivalent subsidy <input type="checkbox"/> Rental by client, with HCV voucher (tenant or project) <input type="checkbox"/> Rental by client in a public housing unit <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected															
<b>LENGTH OF STAY IN PRIOR LIVING SITUATION</b> (How long did the client stay in that situation?)															
<input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> One month or more, but less than 90 days <input type="checkbox"/> 90 days or more, but less than one year <input type="checkbox"/> One year or longer <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected															
<b>If Client is being enrolled into <u>PATH STREET OUTREACH</u>, or Prior Living Situation = <u>HOMELESS</u></b>															
<b>APPROXIMATE DATE HOMELESSNESS STARTED</b> (for the client's <u>current</u> episode of homelessness)															
				MONTH				DAY				YEAR			
<b>Number of times the client has been on the streets, in ES, or Safe Haven in the past three years including today</b> (Regardless of where they stayed last night)															
<input type="checkbox"/> One time <input type="checkbox"/> Two times <input type="checkbox"/> Three times <input type="checkbox"/> Four or more times <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected															
<b>Total number of months homeless on the streets, in ES, or SH in the past three years</b>															
<input type="checkbox"/> One month (first time) <input type="checkbox"/> Two months <input type="checkbox"/> Three months <input type="checkbox"/> Four months <input type="checkbox"/> Five months <input type="checkbox"/> Six months <input type="checkbox"/> Seven months <input type="checkbox"/> Eight months <input type="checkbox"/> Nine months <input type="checkbox"/> Ten months <input type="checkbox"/> Eleven months <input type="checkbox"/> Twelve months <input type="checkbox"/> More than 12 months <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected															



If Client enrollment is in **PATH SERVICES ONLY**

AND

Prior Living Situation = **TRANSITIONAL HOUSING** or **PERMANENT HOUSING**

**Length of Stay Less than 7 nights?**

*(Indicate if the stay in the Transitional or Permanent Housing setting they lived in immediately prior to project entry was less than 7 nights)*

- No  
 Yes\*

**\*If YES to Length of Stay Less than 7 nights**

**On the night before – stayed on the Streets, Emergency Shelter, or Safe Haven?**

*(On the night before the client's stay of less than 7 nights in a Transitional or Permanent Housing setting, were they on the Streets, in an Emergency Shelter, or in a Safe Haven?)*

- No  
 Yes\*

**\*If YES to 'On the night before – stayed on the Streets, Emergency Shelter, or Safe Haven'**

**APPROXIMATE DATE HOMELESSNESS STARTED**

*(for the client's **current** episode of homelessness)*

MONTH			DAY			YEAR			

**Number of times the client has been on the streets, in ES, or Safe Haven in the past three years including today** *(Regardless of where they stayed last night)*

- One time                       Three times                       Client doesn't know  
 Two times                       Four or more times                       Client refused  
 Data not collected

**Total number of months homeless on the streets, in ES, or SH in the past three years**

- One month (first time)       Five months                       Nine months                       More than 12 months  
 Two months                       Six months                       Ten months                       Client doesn't know  
 Three months                       Seven months                       Eleven months                       Client refused  
 Four months                       Eight months                       Twelve months                       Data not collected

**DATE OF ENGAGEMENT**

*(Leave blank if this has not happened yet)*

MONTH			DAY			YEAR			

**PATH STATUS**

**Date of Status Determination:**

*(Leave blank if this has not happened yet)*

MONTH			DAY			YEAR			

**\*If Status Determination Date is entered**

**Client became Enrolled in PATH?**

- No\*                       Yes

**\*If NO to Client became Enrolled in PATH**

**Reason not Enrolled:**

- Client was found ineligible for PATH  
 Client was found ineligible for other reasons  
 Unable to locate client

DISABLING CONDITION	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
PHYSICAL DISABILITY	
<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>*If YES for Physical Disability</b> <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
DEVELOPMENTAL DISABILITY	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
CHRONIC HEALTH CONDITION	
<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>*If YES for Chronic Health Condition</b> <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
HIV/AIDS	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
MENTAL HEALTH PROBLEM	
<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>*If YES for Mental Health Problem</b> <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
SUBSTANCE ABUSE PROBLEM	
<input type="checkbox"/> No <input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Drug abuse <input type="checkbox"/> Both alcohol and drug abuse	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>*If YES for Substance Abuse Problem</b> <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

DOMESTIC VIOLENCE VICTIM/SURVIVOR		
	<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
*If YES to Domestic Violence Victim/Survivor		
When did this experience occur?	<input type="checkbox"/> Within the past three months <input type="checkbox"/> Three to six months ago (excluding six months exactly) <input type="checkbox"/> From six to twelve months ago (excluding one year exactly) <input type="checkbox"/> More than a year ago	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Are you currently fleeing?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

CASH INCOME FOR INDIVIDUAL	
Income from Any Source?	<input type="checkbox"/> No <input type="checkbox"/> Yes* <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
*If YES to Income from Any Source – Indicate all sources that apply	
Income Source (Check all that apply)	Monthly Amount
<input type="checkbox"/> Earned Income	
<input type="checkbox"/> Unemployment Insurance	
<input type="checkbox"/> Supplemental Security Income (SSI)	
<input type="checkbox"/> Social Security Disability Insurance (SSDI)	
<input type="checkbox"/> VA Service-Connected Disability Compensation	
<input type="checkbox"/> VA Non-Service Connected Disability Pension	
<input type="checkbox"/> Private Disability Insurance	
<input type="checkbox"/> Worker's Compensation	
<input type="checkbox"/> Temporary Assistance for Needy Families (TANF)	
<input type="checkbox"/> General Assistance (GA)	
<input type="checkbox"/> Retirement Income from Social Security	
<input type="checkbox"/> Pension or Retirement Income from a Former Job	
<input type="checkbox"/> Child Support	
<input type="checkbox"/> Alimony and Other Spousal Support	
<input type="checkbox"/> Other Cash Income (Specify: _____)	
<b>Total Monthly Amount</b>	

NON-CASH BENEFITS	
<b>Receiving Non-Cash Benefits?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes* <div style="float: right;"> <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused  <input type="checkbox"/> Data not collected </div>
<b>*If YES to Receiving Non-Cash Benefits – Indicate all sources that apply</b>	
<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) <div style="float: right;"><input type="checkbox"/> TANF Transportation Services</div> <input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) <div style="float: right;"><input type="checkbox"/> Other TANF-Funded Services</div> <input type="checkbox"/> TANF Childcare Services <div style="float: right;"><input type="checkbox"/> Other Non-Cash Benefit (Specify source: _____)</div>	

HEALTH INSURANCE	
<b>Covered by Health Insurance?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes* <div style="float: right;"> <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused  <input type="checkbox"/> Data not collected </div>
<b>*If YES to Covered by Health Insurance – Indicate all sources that apply</b>	
<input type="checkbox"/> Medicaid <div style="float: right;"><input type="checkbox"/> Health Insurance Obtained Through COBRA</div> <input type="checkbox"/> Medicare <div style="float: right;"><input type="checkbox"/> Private Pay Health Insurance</div> <input type="checkbox"/> State Children's Health Insurance Program <div style="float: right;"><input type="checkbox"/> State Health Insurance for Adults</div> <input type="checkbox"/> Veteran's Administration (VA) Medical Services <div style="float: right;"><input type="checkbox"/> Indian Health Services Program</div> <input type="checkbox"/> Employer-Provided Health Insurance <div style="float: right;"><input type="checkbox"/> Other Health Insurance (Specify source: _____)</div>	

<b>Would you like to share the reasons or factors you feel contributed to your homelessness?</b>	<input type="checkbox"/> No <div style="float: right;"><input type="checkbox"/> Yes*</div>
<b>*If YES please indicate all reasons that apply</b>	
<input type="checkbox"/> Abuse or violence in my home <div style="float: right;"><input type="checkbox"/> Lost a job, could not find work</div> <input type="checkbox"/> Alcohol or substance use problems <div style="float: right;"><input type="checkbox"/> Medical Expenses</div> <input type="checkbox"/> Asked to leave or evicted <div style="float: right;"><input type="checkbox"/> Mental health condition</div> <input type="checkbox"/> Bad credit <div style="float: right;"><input type="checkbox"/> Moved to find work</div> <input type="checkbox"/> Client Choice <div style="float: right;"><input type="checkbox"/> Problems with public benefits</div> <input type="checkbox"/> COVID-19 <div style="float: right;"><input type="checkbox"/> PTSD</div> <input type="checkbox"/> Disabling conditions <div style="float: right;"><input type="checkbox"/> Reasons related to my race or ethnicity</div> <input type="checkbox"/> Discharged from foster care <div style="float: right;"><input type="checkbox"/> Reasons related to my sexual orientation or gender identity</div> <input type="checkbox"/> Discharged from jail <div style="float: right;"><input type="checkbox"/> Relationship problems or family breakup</div> <input type="checkbox"/> Discharged from prison <div style="float: right;"><input type="checkbox"/> Traumatic brain injury</div> <input type="checkbox"/> Family member or personal illness <div style="float: right;"><input type="checkbox"/> Unable to pay rent or mortgage</div> <input type="checkbox"/> Language barrier <div style="float: right;"><input type="checkbox"/> Unable to pay utilities</div> <input type="checkbox"/> Legal problems <div style="float: right;"><input type="checkbox"/> Other reason (Please specify: _____)</div>	

<b>CONTACT INFORMATION</b> (Optional – entered on the <b>Contacts</b> tab)	
Phone number	
Email	

<b>ADDRESS</b> (Optional – entered on the <b>Locations</b> tab)			
Street			
City			
State		Zip Code	

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Signature of applicant stating all information is true and correct

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Date