



COHMIS

PATH Assessment Form

CLIENT NAME			
Last:			
First:			
Middle:		Suffix	

PROJECT NAME									
ASSESSMENT DATE (MM/DD/YYYY)									
ASSESSMENT TYPE	<input type="checkbox"/> Annual Assessment				<input type="checkbox"/> Status Update				

CONNECTION WITH SOAR	<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	

DATE OF ENGAGEMENT									
<i>(If the client was Engaged, be sure to enter this date on the client's Enrollment screen)</i>									
	MONTH			DAY		YEAR			

PATH STATUS									
Date of Status Determination:									
<i>(Leave blank if this has not happened yet)</i>									
*If Status Determination Date is entered									
Client became Enrolled in PATH?	<input type="checkbox"/> No*				<input type="checkbox"/> Yes				
*If NO to Client became Enrolled in PATH									
Reason not Enrolled:	<input type="checkbox"/> Client was found ineligible for PATH <input type="checkbox"/> Client was found ineligible for other reasons <input type="checkbox"/> 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
*If YES for Physical Disability <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
*If YES for Chronic Health Condition <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
*If YES for Mental Health Problem <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
*If YES for Substance Abuse Problem <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: _____)	
Total Monthly Amount	

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

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

CONTACT INFORMATION (Optional – entered on the Contacts tab)	
Phone number	
Email	

ADDRESS (Optional – entered on the Locations tab)			
Street			
City			
State		Zip Code	

Signature of applicant stating all information is true and correct

Date