

HHS PATH Entry for SO 2020

Please complete one sheet for each person served, whether they are an individual or a family member

Project Start Date: ____/____/____ **Project Name:** _____

ServicePointClient ID _____

First Name: _____ **MI:** _____ **Last Name:** _____ **Suffix:** _____

Name Type: Full Name Reported
 Partial, Street Name, or Code Name Reported
 Client Doesn't Know
 Client Refused
 Data Not Collected

SSN: _____ - _____ - _____ **SSN Type:** Full
 Approximate/Partial
 Client Doesn't Know
 Client Refused
 Data Not Collected

U.S. Military Veteran? (clients 18 and older): Yes No Client Doesn't Know Client Refused Data Not Collected

DOB(mm/dd/yyyy) ____/____/____ **DOB Type:** Full DOB
 Approximate or Partial DOB
 Client Doesn't Know
 Client Refused
 Data Not Collected

Primary Race: American Indian or Alaska Native White
 Asian Client Doesn't know
 Black/African American Client Refused
 Native Hawaiian or Other Pacific Islander Data Not Collected

Secondary Race: American Indian or Alaska Native White
 Asian Client Doesn't know
 Black/African American Client Refused
 Native Hawaiian or Other Pacific Islander Data Not Collected

Ethnicity: Non-Hispanic /Latino
 Hispanic/Latino
 Client Doesn't Know
 Client Refused
 Data Not Collected

Gender: Female Gender non-conforming {IE not exclusively male or female}
 Male Client Doesn't Know
 Trans Female (MTF male to female) Client Refused
 Trans Male (FTM or female to male) Data Not Collected

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Do you have a disabling condition? Yes No Client Doesn't Know Client Refused Data Not Collected

Relationship to Head of Household: Self
 Head of Household's Child
 Head of Household's Spouse or Partner
 Head of Household's other relation member
 Other Non-Related Member
 Data Not Collected

Prior Living Situation:

-HOMELESS SITUATION-

- Place Not Meant for Habitation
- Emergency Shelter, including hotel/motel paid for w/ES voucher, or RHY-funded host home shelter
- Safe Haven

-INSTITUTIONAL SITUATIONS-

- Foster Care Home or Foster Care Group Home
- Hospital or other Residential Non-Psychiatric Medical Facility
- Jail, Prison or Juvenile Detention Facility
- Long-Term Care Facility or Nursing Home
- Psychiatric Hospital or Other Psychiatric Facility
- Substance Abuse Treatment Facility or Detox Center

-TEMPORARY AND PERMANENT HOUSING SITUATIONS-

- Residential Project or Halfway House with no Homeless Criteria
- Hotel or Motel Paid for without an Emergency Shelter Voucher
- Transitional Housing for Homeless Persons (includes homeless youth)
- Host Home (non-crisis)
- Staying or Living in a Friend's Room, Apartment or House
- Staying or Living in a Family Member's Room, Apartment or House
- Rental by Client, with GPD TIP Subsidy
- Rental by Client, with VASH Subsidy
- Permanent Housing (other than RRH) for Formerly Homeless Persons
- Rental by Client, with RRH or Equivalent Subsidy
- Rental by Client, with HCV voucher (tenant or project based)
- Rental by Client in a Public Housing Unit
- Rental by Client, No Ongoing Housing Subsidy
- Rental by Client, with Other Ongoing Housing Subsidy
- Owned by Client, with Ongoing Housing Subsidy
- Owned by Client, No Ongoing Housing Subsidy

-OTHER-

- Client Doesn't Know
- Client Refused
- Data Not Collected

Length of stay in previous place: One night or less one year or longer
 Two to six nights Client Doesn't Know
 One week or more but less than one month Client Refused
 One month or more but less than 90 days Data Not Collected
 90 days or more but less than one year

Approximate Date Homelessness Started: _____/_____/_____

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Regardless of where they stayed last night - Number of times the client has been on the streets, in ES, or SH in the past three years including today:

- | | |
|--|--|
| <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 |
|--|--|

Total Number of Months Homeless on the street, in ES or SH in the Past Three Years:

- | | | |
|---|--|--|
| <input type="checkbox"/> One Month (this time is the first month)
<input type="checkbox"/> 2 Months
<input type="checkbox"/> 3 Months
<input type="checkbox"/> 4 Months
<input type="checkbox"/> 5 Months | <input type="checkbox"/> 6 Months
<input type="checkbox"/> 7 Months
<input type="checkbox"/> 8 Months
<input type="checkbox"/> 9 Months
<input type="checkbox"/> 10 Months | <input type="checkbox"/> 11 Months
<input type="checkbox"/> 12 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 |
|---|--|--|

Income from any source? Yes No Client Doesn't Know Client Refused Data Not Collected

Monthly Income

Receiving Income	Source of Income <i>(Check all that apply)</i>	Monthly Amount
<input type="checkbox"/> Yes <input type="checkbox"/> No	Earned Income	\$
<input type="checkbox"/> Yes <input type="checkbox"/> No	Unemployment Insurance	\$
<input type="checkbox"/> Yes <input type="checkbox"/> No	Supplemental Security Income (SSI)	\$
<input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security Disability Income (SSDI)	\$
<input type="checkbox"/> Yes <input type="checkbox"/> No	VA Service Connected Disability Compensation	\$
<input type="checkbox"/> Yes <input type="checkbox"/> No	Private Disability Insurance	\$
<input type="checkbox"/> Yes <input type="checkbox"/> No	Worker's Compensation	\$
<input type="checkbox"/> Yes <input type="checkbox"/> No	Temporary Assistance for Needy Families (TANF)	\$
<input type="checkbox"/> Yes <input type="checkbox"/> No	General Assistance	\$
<input type="checkbox"/> Yes <input type="checkbox"/> No	Retirement Income From Social Security	\$
<input type="checkbox"/> Yes <input type="checkbox"/> No	VA Non-Service Connected Disability Pension	\$
<input type="checkbox"/> Yes <input type="checkbox"/> No	Pension or Retirement Income from Another Job	\$
<input type="checkbox"/> Yes <input type="checkbox"/> No	Child Support	\$
<input type="checkbox"/> Yes <input type="checkbox"/> No	Alimony or Other Spousal Support	\$
<input type="checkbox"/> Yes <input type="checkbox"/> No	Other – Specify Source _____	\$
Total Monthly Income		\$

Non-Cash Benefit from any source? Yes No Client Doesn't Know Client Refused Data Not Collected

Non-Cash Benefits

Receiving Benefit	Source of Non-Cash Benefit <i>(Check all that apply)</i>	Benefit Amount <i>(when applicable)</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Supplemental Nutrition Assistance Program (SNAP – Food Stamps)	\$
<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	\$
<input type="checkbox"/> Yes <input type="checkbox"/> No	TANF Child Care services	\$
<input type="checkbox"/> Yes <input type="checkbox"/> No	TANF Transportation services	\$
<input type="checkbox"/> Yes <input type="checkbox"/> No	Other TANF-funded services	\$
<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Source – Specify Source _____	\$

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Covered by Health Insurance? Yes No Client Doesn't Know Client Refused Data Not Collected

Health Insurance

Covered	Health Insurance Type <i>(Check all that apply)</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	MEDICAID
<input type="checkbox"/> Yes <input type="checkbox"/> No	MEDICARE
<input type="checkbox"/> Yes <input type="checkbox"/> No	State Children's Health Insurance Program
<input type="checkbox"/> Yes <input type="checkbox"/> No	Veteran's Administration (VA) Medical Services
<input type="checkbox"/> Yes <input type="checkbox"/> No	Employer-Provided Health Insurance
<input type="checkbox"/> Yes <input type="checkbox"/> No	Health Insurance obtained through COBRA
<input type="checkbox"/> Yes <input type="checkbox"/> No	Private Pay Health Insurance
<input type="checkbox"/> Yes <input type="checkbox"/> No	State Health Insurance for Adults
<input type="checkbox"/> Yes <input type="checkbox"/> No	Indian Health Services Program
<input type="checkbox"/> Yes <input type="checkbox"/> No	Other – Specify: _____

Health, Substance Abuse, and Disabilities

Disability Type	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently
Physical <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC
Developmental <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC	Not Required <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC
Chronic Health Condition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC
HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC	Not Required <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC
Mental Health Problem <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC
Alcohol Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC
Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC
Both Alcohol and Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC

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Domestic violence victim/survivor? Yes Client Refused
 No Data Not Collected
 Client Doesn't Know

If yes, how long ago? Within the past three months More than a year ago
 Three to six months ago Client Doesn't know
 From six to twelve months ago Client Refused

If yes, are you currently fleeing? Yes Client Refused
 No Data Not Collected
 Client Doesn't Know

Current Living Situation

Start Date: _____/_____/_____

End Date: _____/_____/_____

Information Date: _____/_____/_____

Current Living Situation:

-HOMELESS SITUATIONS-

- Place Not Meant for Habitation
- Emergency Shelter, including hotel/motel paid for w/ES voucher, or RHY-funded host home shelter
- Safe Haven

-OTHER-

- Other
- Worker unable to determine
- Client Doesn't Know
- Client Refused
- Data Not Collected

Date of Engagement: _____/_____/_____

Date of PATH Status Determination: _____/_____/_____

Client Became Enrolled in PATH: Yes No

If no, reason not enrolled: Client was found ineligible for PATH
 Client was not enrolled for other reason(s)
 Unable to locate Client

Connection with SOAR: Yes No Client Doesn't Know Client Refused Data Not Collected

Maine Required Data Elements:

Zip Code of Last Permanent Address: _____

Zip data quality for last permanent address: Full or Partial Zip Code Report Client doesn't know Client refused

Release of Information Date: _____/_____/_____

Type of Release: None Signed by Client Verbal