



MSCCoC_MIS PATH Project End

Community Alliance for the Homeless | Management Information Systems | Tanyce McCray-Davis | MIS Director/System Admin II
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FOR TEXT FIELDS, USE BLOCK LETTERS. OTHERWISE, MARK APPROPRIATE BOXES WITH AN "X". Complete a separate form for each member of the household.

Date of Data Collection							Client ID									
		/			/											
Month		Day			Year											

NAME (first, middle, last name, suffix (e.g., Jr, Sr, III)) [All clients]

First Name:																				
Middle Name:																				
Last Name:																				
Suffix:																				
Alias:																				

Social Security Number: [All clients]

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Date of Birth: (e.g., 10/23/1978) [All clients]

		/			/				
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REASON FOR LEAVING

<input type="checkbox"/> Completed Program	<input type="checkbox"/> Needs Could Not Be Met	<input type="checkbox"/> Reached Maximum Time Allotted
<input type="checkbox"/> Criminal Activity/Violence	<input type="checkbox"/> Non-Compliance with Program	<input type="checkbox"/> Shelter Night Stay Complete
<input type="checkbox"/> Death	<input type="checkbox"/> Non-Payment of Rent	<input type="checkbox"/> Unknown/Disappeared
<input type="checkbox"/> Disagreement with rules/persons	<input type="checkbox"/> Left for Housing opp. Before completing program	<input type="checkbox"/> Other (specify)

DESTINATION

<input type="checkbox"/> Deceased (HUD)	<input type="checkbox"/> Owned by client, with ongoing housing subsidy (HUD)	<input type="checkbox"/> Residential project or halfway house with no homeless criteria (HUD)
<input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher (HUD)	<input type="checkbox"/> Permanent housing for formerly homeless persons (HUD)	<input type="checkbox"/> Safe Haven (HUD) Staying or living with family, permanent tenure (HUD)
<input type="checkbox"/> Foster care home or foster care group home (HUD)	<input type="checkbox"/> Place not meant for habitation (HUD)	<input type="checkbox"/> Staying or living with family, temporary tenure (e.g., room, apartment or house)(HUD)
<input type="checkbox"/> Hospital or other residential non-psychiatric medical facility(HUD)	<input type="checkbox"/> Psychiatric hospital or other psychiatric facility (HUD)	<input type="checkbox"/> Staying or living with friends, permanent tenure (HUD)
<input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher (HUD)	<input type="checkbox"/> Rental by client, no ongoing housing subsidy (HUD)	<input type="checkbox"/> Staying or living with friends, temporary tenure (e.g., room apartment or house)(HUD)
<input type="checkbox"/> Jail, prison or juvenile detention facility (HUD) Longterm care facility or nursing home (HUD)	<input type="checkbox"/> Rental by client, with VASH subsidy (HUD)	<input type="checkbox"/> Substance abuse treatment facility or detox center (HUD)

<input type="checkbox"/>	Moved from one HOPWA funded project to HOPWAPH (HUD)	<input type="checkbox"/>	Rental by client, with GPD TIP subsidy (HUD)	<input type="checkbox"/>	Transitional housing for homeless persons (including homeless youth) (HUD)
<input type="checkbox"/>	Moved from one HOPWA funded project to HOPWA TH (HUD)	<input type="checkbox"/>	Rental by client, with other ongoing housing subsidy (HUD)	<input type="checkbox"/>	Other (HUD)
<input type="checkbox"/>	No exit interview completed (HUD)	<input type="checkbox"/>	Client refused (HUD)	<input type="checkbox"/>	Staying in a family member's apartment/house/room
<input type="checkbox"/>	Client doesn't know (HUD)	<input type="checkbox"/>	Data not collected (HUD)	<input type="checkbox"/>	Permanent: Moved in with family or friends
<input type="checkbox"/>	If "Other", Specify				

INCOME & SOURCES *PROOF NEEDED*

What is the Household total monthly income?

\$ _____

Have you received income from any source? No Yes

If yes for "Income from any source:

Indicate all sources and dollar amounts for the source that apply:

No	Yes	Source of Income	Amount	No	Yes	Source of Income	Amount
<input type="checkbox"/>	<input type="checkbox"/>	Earned income (i.e. employment income)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Worker's Compensation	\$
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Security Income (SSI)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Temporary Assistance for Needy Families (TANF)	\$
<input type="checkbox"/>	<input type="checkbox"/>	Social Security Disability Income (SSDI)	\$	<input type="checkbox"/>	<input type="checkbox"/>	General Assistance (GA)	\$
<input type="checkbox"/>	<input type="checkbox"/>	VA Service Connected Disability Compensation	\$	<input type="checkbox"/>	<input type="checkbox"/>	VA Non Service Connected Disability Pension	\$
<input type="checkbox"/>	<input type="checkbox"/>	Retirement Income from Social Security	\$	<input type="checkbox"/>	<input type="checkbox"/>	Responses Pension or retirement income from a former job	\$
<input type="checkbox"/>	<input type="checkbox"/>	Private disability insurance	\$	<input type="checkbox"/>	<input type="checkbox"/>	Child support	\$
<input type="checkbox"/>	<input type="checkbox"/>	Unemployment Insurance	\$	<input type="checkbox"/>	<input type="checkbox"/>	Alimony and other spousal support	\$
<input type="checkbox"/>	<input type="checkbox"/>	Other Source (specify	\$				

NON-CASH BENEFITS *PROOF NEEDED*

Have you received non-cash benefits 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
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If yes for non-cash benefits from any source and dollar amounts for the source that apply:

No	Yes	Source of Benefit	Amount	No	Yes	Source of Benefit	Amount
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Nutrition Assistance Program (SNAP) (Previously known as Food Stamps)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	\$
<input type="checkbox"/>	<input type="checkbox"/>	SANF Child Care services (or use local name)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Temporary Assistance for Needy Families (TANF)	\$
<input type="checkbox"/>	<input type="checkbox"/>	TANF transportation services (or use local name)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Other TANF unded Services (or use local name)	\$
<input type="checkbox"/>	<input type="checkbox"/>	Section 8, public housing, or other ongoing rental assistance	\$	<input type="checkbox"/>	<input type="checkbox"/>	Temporary rental assistance	\$
<input type="checkbox"/>	<input type="checkbox"/>	Other Source	\$	If yes to "Other" Source, please specify			

Does client have a 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
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ALCOHOL ABUSE

<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date Information Collected:		/		/			
			Month		Day		Year		

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<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
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Is there Documentation of the disability and severity on file?

<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
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Currently receiving services/treatment for this 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
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CHRONIC HEALTH CONDITION

<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date Information Collected:		/		/			
			Month		Day		Year		

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<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
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Is there Documentation of the disability and severity on file?

<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
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Currently receiving services/treatment for this 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
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DEVELOPMENTAL DISABILITY

<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date Information Collected:		/		/			
			Month		Day		Year		

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<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
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Is there Documentation of the disability and severity on file?

<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
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Currently receiving services/treatment for this 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
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HIV/AIDS

<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date Information Collected:		/		/			
			Month		Day		Year		

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<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
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Is there Documentation of the disability and severity on file?

<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
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Currently receiving services/treatment for this 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
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MENTAL HEALTH CONDITION

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:				/		/			
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Month Day Year

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<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
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Is there Documentation of the disability and severity on file?

<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
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Currently receiving services/treatment for this 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
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PHYSICAL CONDITION

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:				/		/			
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Month Day Year

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<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
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Is there Documentation of the disability and severity on file?

<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
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Currently receiving services/treatment for this 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
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INSURANCE INFORMATION *PROOF NEEDED*

Covered by health insurance?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:				/		/			
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HEALTH INSURANCE PROVIDERS

NO	YES		NO	YES	
<input type="checkbox"/>	<input type="checkbox"/>	MEDICAID	<input type="checkbox"/>	<input type="checkbox"/>	Health Insurance obtained through COBRA
<input type="checkbox"/>	<input type="checkbox"/>	MEDICARE	<input type="checkbox"/>	<input type="checkbox"/>	Private Pay Health Insurance
<input type="checkbox"/>	<input type="checkbox"/>	State Children's Health Insurance Program (or use local name)	<input type="checkbox"/>	<input type="checkbox"/>	State Health Insurance for Adults (or use local name)
<input type="checkbox"/>	<input type="checkbox"/>	Veteran's Administration (VA) Medical Services	<input type="checkbox"/>	<input type="checkbox"/>	Indian Health Services Program
<input type="checkbox"/>	<input type="checkbox"/>	Employer - Provided Health Insurance	<input type="checkbox"/>	<input type="checkbox"/>	Other

OUTREACH/ENGAGEMENT INFORMATION

Date of Contact

		/			/			
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Month Day Year

Staying on Street, ES, or SH Staying on Street, ES, or SH

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Worker unable to determine
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Start Date:

		/			/				
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Month Day Year

End Date:

		/			/				
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Month Day Year

Date of Engagement:

		/			/				
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Month Day Year

Date of PATH status determination:

		/							
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Month Day Year

Enrolled in Path

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes
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If No, reason not enrolled

<input type="checkbox"/>	Client was for ineligible for PATH	<input type="checkbox"/>	Client was enrolled for other reasons
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Connection with SOAR

<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
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