



Client Location: TN-501

**Relationship to Head of Household [All clients]**

<input type="checkbox"/>	Self (Head of Household & Singles)	<input type="checkbox"/>	Head of household's other relation member
<input type="checkbox"/>	Head of household's child	<input type="checkbox"/>	Other: non-relation member
<input type="checkbox"/>	Head of household's spouse or partner	<input type="checkbox"/>	Specify Relation: _____

**DOMESTIC VIOLENCE VICTIM (ALL CLIENTS)**

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes
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**If Victim of DV - How Long Ago? (All Clients)**

<input type="checkbox"/>	1 Day to 3 Months	<input type="checkbox"/>	More than a Year
<input type="checkbox"/>	3 Months to 6 Months	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	6 Months to 1 Year	<input type="checkbox"/>	Client refused

**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
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**HOMELESS INFORMATION**

**Residence Prior to Project Entry?**

<input type="checkbox"/>	Place not meant for habitation	<input type="checkbox"/>	Emergency shelter, including hotel or motel paid for with emergency shelter voucher	<input type="checkbox"/>	Interim Housing
<input type="checkbox"/>	Foster care home or foster care group home	<input type="checkbox"/>	Jail, prison or juvenile detention facility	<input type="checkbox"/>	Psychiatric hospital or other psychiatric facility
<input type="checkbox"/>	Hospital or other residential non-psychiatric medical facility	<input type="checkbox"/>	Long-term care facility or nursing home	<input type="checkbox"/>	Substance abuse treatment facility or detox center
<input type="checkbox"/>	Hotel or motel paid for without emergency shelter voucher	<input type="checkbox"/>	Rental by client, with VASH subsidy	<input type="checkbox"/>	Staying or living in a friend's room, apartment or house
<input type="checkbox"/>	Owned by client, no ongoing housing subsidy	<input type="checkbox"/>	Rental by client, with GPD TIP subsidy	<input type="checkbox"/>	Transitional housing for homeless persons (including homeless youth)
<input type="checkbox"/>	Owned by client, with ongoing housing subsidy	<input type="checkbox"/>	Rental by client, with other ongoing housing subsidy	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Permanent housing for formerly homeless persons (such as: a CoC project; HUD legacy programs; or HOPWA PH)	<input type="checkbox"/>	Residential project or halfway house with no homeless criteria	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Rental by client, no ongoing housing subsidy	<input type="checkbox"/>	Staying or living in a family member's room, apartment or house	<input type="checkbox"/>	Data not collected
<input type="checkbox"/>	VA Medical Referral				

**Length of Stay in Prior Living 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
<input type="checkbox"/>	Unknown				

**Approximate date homelessness started:**

		/			/				
Month			Day			Year			

**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"/> Hospital or other residential non-psychiatric medical facility	<input type="checkbox"/> Long-term care facility or nursing home	<input type="checkbox"/> Substance abuse treatment facility or detox center

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

<input type="checkbox"/> One month (this is the first time)	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8
<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12
<input type="checkbox"/> More than 12	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected

**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			

**DISABILITY INFORMATION \*PROOF NEEDED\***

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:			/			/			
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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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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 Insurances	<input type="checkbox"/>	<input type="checkbox"/>	Other

Date of Engagement:

		/			/				
Month			Day			Year			

Date of PATH status determination:

		/			/				
Month			Day			Year			

Client 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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