



# MSCCoC\_MIS PATH Project Interim

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

		/			/			
Month			Day			Year		

Client ID

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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]

		/			/				
Month			Day			Year			

INCOME & SOURCES \*PROOF NEEDED\*

What is the Household total monthly income?

\$ \_\_\_\_\_

Have you received 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
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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:				/		/			
							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:				/		/			
							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:				/		/			
							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
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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

### Date of Engagement:

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			

### Date of PATH status determination:

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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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