HHS PATH Intake Assessment

This form is to be used in assisting case managers, intake workers, and HMIS users to record client level program specific data elements for input into Servicepoint.

Project: ______________________________ **Date:** ____________________

Client Name: ____

SSN: ____________________

SSN Data Quality:
- ☐ Full SSN reported
- ☐ Approximate or partial SSN reported
- ☐ Client doesn't know
- ☐ Client refused
- ☐ Data not collected

U.S. Military Veteran?
- ☐ Yes
- ☐ No
- ☐ Client doesn't know
- ☐ Client refused
- ☐ Data not collected

Date of Birth: ______________

Date of Birth Type:
- ☐ Full DOB reported
- ☐ Approximate or partial DOB reported
- ☐ Client doesn't know
- ☐ Client refused

Gender:
- ☐ Female
- ☐ Male
- ☐ Transgendered Female to Male
- ☐ Transgendered Male to Female
- ☐ Other
- ☐ Client doesn't know
- ☐ Client refused
- ☐ Data not collected

Other: ______________

Primary Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Client doesn't know
- ☐ Client refused
- ☐ Data not collected

Secondary Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Client doesn't know
- ☐ Client refused
- ☐ Data not collected

Ethnicity:
- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Non-Latino
- ☐ Client doesn't know
- ☐ Client refused
- ☐ Data not collected

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Client Name: ______________________ Date of Birth: ______________
Social Security #: ______________

I request and authorize: ______________________________ at
Staff Person(s)

Agency Name: ______________________________

Project Name: ______________________________

to disclose confidential information to HMIS-ERIE, the homeless database which supports the Erie, PA Continuum of Care PA-605 administered by EUMA at:

EUMA
1033 East 26th Street
Erie, PA 16504

This request and authorization applies to:

☐ Client demographics and HUD program entry/exit information

☐ Case Management Information for the purpose of services and referrals, and/or: ______________

☐ Yes ☐ No I expressly release the above named staff person(s) and Agency from any and all liability arising from compliance with this request and disclosure of the requested information to HMIS-ERIE and EUMA.

Client Signature: ______________________ Date Signed: ______________

☐ Yes ☐ No I understand my rights regarding personally identifying information as explained by the above named staff person(s) and outlined in the HMIS-ERIE Consumer Privacy Policy. I authorize the release of my information, such as personal demographics, income, health, and disabilities (including drug, alcohol, and/or mental health treatment) to HMIS-ERIE.

Client Signature: ______________________ Date Signed: ______________

☐ Yes ☐ No I authorize my information to be shared with other HMIS-ERIE providers to send and receive referrals and coordinate services between HMIS-ERIE providers.

Client Signature: ______________________ Date Signed: ______________

Staff Signature : ______________________ Date Signed: ______________

THIS AUTHORIZATION EXPIRES ONE (1) YEAR AFTER IT IS SIGNED.

Entry

Date of Entry: ________________________

Residence Prior to Project Entry:

- ○ Emergency shelter, including hotel or motel paid for with emergency shelter voucher
- ○ Foster care home or foster care group home
- ○ Hospital or other residential non-psychiatric medical facility
- ○ Hotel or motel paid for without emergency shelter voucher
- ○ Jail, prison or juvenile detention facility
- ○ Long-term care facility or nursing home
- ○ Owned by client, no ongoing housing subsidy
- ○ Owned by client, with ongoing housing subsidy
- ○ Permanent housing for formerly homeless persons
- ○ Place not meant for habitation
- ○ Psychiatric hospital or other psychiatric facility
- ○ Rental by client, no ongoing housing subsidy
- ○ Rental by client, with VASH subsidy
- ○ Rental by client, with GPD TIP subsidy
- ○ Rental by client, with other ongoing housing subsidy
- ○ Residential project or halfway house with no homeless criteria
- ○ Safe Haven
- ○ Staying or living in a family member's room, apartment or house
- ○ Staying or living in a friend's room, apartment or house
- ○ Substance abuse treatment facility or detox center
- ○ Transitional housing for homeless persons (including homeless youth)
- ○ Other:________________________
- ○ Client doesn't know
- ○ Client refused
- ○ Data not collected

Length of Stay:

- ○ One day or less
- ○ Two days to one week
- ○ More than one week, but less than one month
- ○ One to three months
- ○ More than three months, but less than one year
- ○ One year or longer
- ○ Client doesn't Know
- ○ Client refused
- ○ Data not collected

Relationship to Head of Household:

- ○ Self (head of household)
- ○ Head of household's child
- ○ Head of household's spouse or partner
- ○ Head of household's other relation member
- ○ Other: non-relation member
- ○ Data not collected

Client Location: PA-605

Housing Status:

- ○ Homeless
- ○ At imminent risk of losing housing
- ○ Homeless only under other federal statutes
- ○ Fleeing domestic violence
- ○ At-risk of homelessness – Prevention programs only
- ○ Stably Housed
- ○ Data not collected

Client entering from the streets, ES or SH?

- ○ Yes
- ○ No
- ○ Client doesn't know
- ○ Client refused
- ○ Data not collected

If Yes for "Client entering from the streets, ES or SH – Approximate date started: ___/___/______

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

- ○ Never in the three years
- ○ One time
- ○ Two times
- ○ Three times
- ○ Four times
- ○ Client doesn't know
- ○ Client refused
- ○ Data not collected

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

- ○ ___ (1-12)
- ○ More than 12 months
- ○ Client doesn't know
- ○ Client Refused
- ○ Data not collected

Length of Time Homeless-Status Documented? ○ Yes ○ No

Does the client have a disabling condition?:
○ Yes
○ No
○ Client doesn't know
○ Client refused
○ Data not collected

If yes, check all that apply:
○ Alcohol Abuse
○ Both alcohol and drug abuse
○ Chronic Health Condition
○ Developmental
○ Drug Abuse
○ HIV/AIDs
○ Mental Health Problem
○ Physical
○ Physical/Medical

Disability determination:
○ Yes
○ No
○ Client doesn't know
○ Client refused
○ Data not collected

If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?
○ Yes
○ No
○ Client doesn't know
○ Client refused
○ Data not collected

If Yes, Documentation of the disability and severity on file:
○ Yes
○ No

If Yes for Mental Health, Alcohol, Drug, or Both, how confirmed?
○ Unconfirmed; presumptive or self-report
○ Confirmed through assessment and clinical evaluation
○ Confirmed by prior evaluation or clinical records

If Yes for Mental Health, is it a Serious Mental Illness (SMI), and if yes, how confirmed?
○ No
○ Unconfirmed; presumptive or self-report
○ Confirmed through assessment and clinical evaluation
○ Confirmed by prior evaluation or clinical records
○ Client doesn't know
○ Client refused

(If yes) Currently receiving services or treatment:
○ Yes
○ No
○ Client doesn't know
○ Client refused
○ Data not collected

Note on Disability: ____

Above condition is going to be long term?
○ Yes
○ No

Income from Any Source:
○ Yes
○ No
○ Client doesn't know
○ Client refused
○ Data not collected

Source of Income:

$_____Alimony or other spousal support
$_____Child support
$_____Earned Income
$_____General Assistance
$_____Other: __________________________
$_____Pension or retirement from a former job
$_____Private disability insurance
$_____Retirement income from Social Security
$_____Social Security Disability Income (SSDI)
$_____Supplemental Security Income (SSI)
$_____Temporary Assistance for Needy Families (TANF)
$_____Unemployment Insurance
$_____VA non-service-connected disability pension
$_____VA service-connected disability compensation
$_____Worker's compensation

Total Monthly Income: ____________

Non-cash benefit from any source: ○ Yes ○ No ○ Client doesn't know ○ Client refused ○ Data not collected

Source of Non-Cash Benefit:

$_____Supplemental Nutrition Assistance Program (SNAP)
$_____Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
$_____TANF child care services
$_____TANF transportation services
$_____Other TANF-funded services
$_____Section 8, public housing, or other ongoing rental assistance
$_____Other: ____
$_____Temporary rental assistance

Receiving Benefits? ○ Yes ○ No ○ Data not collected

Covered by Health Insurance: ○ Yes ○ No ○ Client doesn't know ○ Client refused ○ Data not collected

Health Insurance Type:

○ MEDICAID
○ MEDICARE
○ State's Children Health Insurance Program
○ Veteran's Administration (VA) Medical Services
○ Employer-Provided Health Insurance
○ Health Insurance obtained through COBRA
○ State Health Insurance for Adults
○ Private Pay Health Insurance

Covered?: ○ Yes ○ No ○ Data not collected

Date of Engagement:___________

Date of PATH Status Determination: ____________

Client Became Enrolled in PATH: ○ Yes ○ No

If no, reason not enrolled:
○ Enrollment Pending
○ Refused/Decided Not to Enroll
○ Moved/Missing

Domestic violence victim/survivor: ○ Yes ○ No ○ Client doesn't know ○ Client refused ○ Data not collected

Extent of Domestic Violence (how long ago):

○ Within the past three months
○ Three to six months ago
○ From six to one year
○ More than a year ago
○ Client doesn't know
○ Client refused
○ Data not collected