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PATH Entry Assessment for SSO
Answer the following questions for ALL Adults and HoH

Client Name: _____
Project Start Date: _____
SS#: ____-____-____ **DOB** ____/____/____

ROI Signed? Yes ____ No ____
Veteran? Yes ____ No ____

Race: (Select as many as client identifies)
 American Indian/ Alaska Native or Indigenous
 Asian or Asian American
 Black, African American, or African
 Native Hawaiian or Pacific Islander
 White

Ethnicity: Hispanic/ Latin(a)(o)(x)
 Non-Hispanic/ Latin(a)(o)(x)

Gender: (Select as many as client identifies)
 Female
 Male
 Transgender (clients who live or identify with a transgender history, experience, or identity)
 A gender that is not singularly 'Female' or 'Male' (e.g., non-binary, genderfluid, agender, culturally specific gender)
 Questioning (Unsure, may be exploring, or may not relate to or identify with a gender identity at this time)

Relationship to Head of Household:
 Self (Head of Household)
 Head of Household's Child
 Head of Household's Spouse/ Partner
 Head of Household's Other Relation Member
 Other: Non-Relation Member

Primary Language: Arabic Armenian Bangali Cantonese Chinese English
 French French Creole German Greek Gujarati Haitian Creole Hebrew
 Hindi Hmong Italian Japanese Korean Mandarin Panjabi Persian
 Polish Portuguese Russian Spanish Tagalog Telugu Urdu
 Vietnamese Yiddish

The following questions should be asked and updated for every new entry into housing:

Medical Insurance:

Do you have Health Insurance/ Medical Assistance? ____ Yes ____ No

Source of Health Insurance/ Medical Assistance:

Medicaid Medicare
 State Children's Health Insurance Program Veteran's Administration (VA) Medical Services
 Employer – Provided Health Insurance Health Insurance obtained through COBRA
 State Health Insurance for Adults
 Indian Health Care Other

Medicaid ID# _____



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Medicaid Insurance Company: Total Care Blue Cross Blue Shield Fidelis
 United Healthcare Molina Healthcare

Disabling Condition:

Do you have a DISABILITY of long duration? Yes No

For each disability, check "LCI" if it is expected to be of long, continued and indefinite duration, substantially impairs the individual's ability to live independently, and is of such a nature that such ability could be improved by more suitable housing conditions.

Disability Type:

Yes LCI Alcohol Use Disorder Yes LCI BOTH Alcohol & Drug Use Disorder Yes LCI Drug Use Disorder
 Yes LCI Chronic Health Condition Yes LCI Developmental HIV/AIDS
 Yes LCI Mental Health Disorder Yes LCI Physical Health

Housing Move In Date: ___/___/___ (Complete if client is in PERMANENT HOUSING)

Zip Code of Last Permanent Address: _____

Residence Prior to Project Entry (Where did you sleep last night?)

Homeless Situation: (If client was homeless, skip to the next page and answer "Homeless Situation Questions")

- Place not meant for human habitation
- Emergency shelter, including hotel or motel paid for with emergency shelter voucher
- Safe Haven
- Interim Housing

Institutional Situation:

- Foster care home/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/detox center

Did you stay less than 90 days? Yes No

If yes, prior to Institutional Stay were you living on the streets or in a shelter? Yes No

(If yes, answer the Homeless Situation Questions)

Transitional and Permanent Housing Situation: (Do not answer Homeless Situation Questions)

- Hotel or motel paid without emergency voucher Owned by client, no on-going housing subsidy
- Owned by client, with on-going housing subsidy
- Permanent housing (other than RRH) for formerly homeless persons
- 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
- Staying in family member's room/apartment/house
- Staying in friend's room/apartment/house
- Transitional housing for homeless persons (including homeless youth)

Homeless Situation Questions: (Only answer if prior living situation was a Homeless Situation)



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Length of Stay in Previous Place:

One day or less Two days to one week More than one week, less than one month
 One to three months More than three months, less than one year One year or longer

Approximate Date Homelessness Started: ___/___/___

of times (episodes) on streets or in ES in 3 years: ___1 ___2 ___3 ___4 or more

Total number of months homeless on the street, in ES in the past 3 years: _____ Months

Income:

Do you have income? ___ Yes ___ No **Total Monthly Income \$** _____

Income Source and amount:

<input type="checkbox"/> Alimony/ Spousal Support	<input type="checkbox"/> Child Support
<input type="checkbox"/> Earned Income	<input type="checkbox"/> General Assistance
<input type="checkbox"/> Pension or retirement income from another job	
<input type="checkbox"/> Private Disability Insurance	<input type="checkbox"/> Retirement Income from Social Security
<input type="checkbox"/> Social Security Disability Income (SSDI)	<input type="checkbox"/> Social Security Income (SSI)
<input type="checkbox"/> Temporary Assist for Needy Families TANF	<input type="checkbox"/> Unemployment Insurance
<input type="checkbox"/> VA Non-Service-Connected Disability Pension	<input type="checkbox"/> VA Service-Connected Disability Compensation
<input type="checkbox"/> Worker's Compensation	

Non-Cash Benefits:

Do you have Non-Cash Benefits? ___ Yes ___ No **Monthly Amount \$** _____

Source of Non-Cash Benefits:

Supplemental Nutrition Assistance Program (SNAP) (HUD) (Previously known as Food Stamps)
 Special supplemental Nutrition Program for (WIC) (HUD)
 TANF Child Care Services (HUD)
 TANF Transportation Services (HUD)
 Other TANF-Funded Services (HUD); If "Other" Specify: _____

Are you a Victim/ Survivor of Domestic Violence? ___ Yes ___ No

If yes, when did it last occur: ___ Within the past 3 months ___ 3 to 6 months ___ 6 to 12 months
___ More than 12 months ___ Refused

Are you currently fleeing? ___ Yes ___ No

Date of Engagement: ___/___/___ (Complete upon client entering Service Plan development or fully completed initial assessment)

Date of PATH Status Determination: ___/___/___

Client Became Enrolled in PATH: ___ Yes ___ No

If no, reason not enrolled: ___ Client found ineligible for PATH ___ Client was not enrolled for other reason(s)
Connection to SOAR: ___ Yes ___ No

Current Living Situation: (Street Outreach ONLY)

Start Date: ___/___/___

End Date: ___/___/___



Information Date: ___/___/___

Current Living Situation:

Homeless Situation (chose only one):

- Place not meant for human habitation
- Emergency shelter, including hotel or motel paid for with emergency shelter voucher
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Transitional and Permanent Housing Situation:

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Other:

- Other: Specify _____
- Worker Unable to Determine

Living Situation verified by: (Agency/ Program Name): _____

Is Client Going to have to leave their current living situation within 14 days? ___ Yes ___ No

If "Yes" to 'Is client going to have to leave their current living situation within 14 days?' answer the following questions:

Has a subsequent residence been identified? ___ Yes ___ No

Does individual or family have resources or support networks to obtain other permanent housing?
___ Yes ___ No

Has the client had a lease or ownership interest in a permanent housing unit in the last 60 days?
___ Yes ___ No

Has the client moved 2 or more times in the last 60 days? ___ Yes ___ No

Location details:



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Legal Status:

Are you on Parole: ___ Yes ___ No If yes, Parole Officer: _____

Phone Number: _____ - _____ - _____

Reasons for Homelessness (Please answer for each adult in the household, if they are living in a homeless situation)

In the past year (12 months), did you experience any of the following:

1. Doubled up with friends or family for more than 1 week? ___ Yes ___ No
2. Lived in a place where an eviction suit was brought against you or the lease holder? ___ Yes ___ No
3. Lived in a place that was declared unfit for human habitation by city/town code enforcement? ___ Yes ___ No
4. Received public assistance from the county and lost it for any reason? ___ Yes ___ No
5. Went to the emergency room or hospital for mental health reasons? ___ Yes ___ No
6. Had a large medical expense? ___ Yes ___ No
7. Released from state prison or other long-term criminal justice institution? ___ Yes ___ No
8. Had some other involvement with the criminal justice system (including probation/parole) ___ Yes ___ No
9. Had utilities shut off? ___ Yes ___ No

Personal Phone Number: _____ - _____ - _____