

Collection Point: Entry
Projects/grants: PATH
Clients who are: Head of Households & Adults

“\*” Required Fields

**1 Client Demographics**

<b>First Name:*</b> _____		<b>Last Name:*</b> _____	
<b>Middle Name:</b> _____		<b>Suffix:</b> _____	
<b>HoH: *</b> _____			

<b>Name Data Quality:*</b> <input type="checkbox"/> Full Name Reported <input type="checkbox"/> Partial, or Street Name <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<b>Social Security Number:*</b> _____ <input type="checkbox"/> Full SSN Reported <input type="checkbox"/> Approximate or Partial SSN <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<b>Birthdate:*</b> _____ <input type="checkbox"/> Full DOB Reported <input type="checkbox"/> Approximate or Partial DOB <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected
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<b>Gender:*</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Gender Non-Conforming (i.e. not exclusively male or female) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<b>Race:*(Select all that apply)</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<b>Ethnicity:*</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected
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<b>If Female, Pregnancy Status:*</b> <input type="checkbox"/> Yes Due Date: _____ <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<b>Veteran Status:*(18 &amp; over)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<b>Relationship to Head of Household:*</b> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other Family Member <input type="checkbox"/> Other Non-Family Member
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**Client Contact Information:**

Email: \_\_\_\_\_ Home Phone: \_\_\_\_\_

**2 Project Enrollment**

<b>Project Start Date:*</b> _____	<b>Case Manager:</b> _____
<b>Date of Engagement:</b> _____	<b>Client became enrolled in PATH?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Date PATH Status Determined</b> _____	

If yes here, skip to Section 3 (below); if "no", provide reason. →

<b>Reason not enrolled in PATH?</b> <input type="checkbox"/> Found ineligible for PATH <input type="checkbox"/> Not enrolled for other reason(s)
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**3 Entry Assessment**

<b>Disabling Condition:*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<b>Client Location (The CoC the client is being served in):*</b> <input type="checkbox"/> (GA-500) Atlanta <input type="checkbox"/> (GA-501) Balance of State <input type="checkbox"/> (GA-502) Fulton County <input type="checkbox"/> (GA-503) Athens/Clarke County <input type="checkbox"/> (GA-504) Augusta <input type="checkbox"/> (GA-505) Columbus/Russell County <input type="checkbox"/> (GA-506) Marietta/Cobb <input type="checkbox"/> (GA-507) Savannah/Chatham County <input type="checkbox"/> (GA-508) DeKalb County
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From the options below, choose **ONLY** one 'type of situation' that most closely matches where the client was living on the night before the enrollment. Adult members of the same household may have different prior living situations.

**HOMELESS SITUATION**

Place not meant for habitation

Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter.

Safe Haven

**INSTITUTIONAL SITUATION**

Foster care home or 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 or Detox Center

**4.1 | Stay less than 90 days?\***

No       Yes

**Length of stay in the prior living situation**

<input type="checkbox"/> 1 night or less	<input type="checkbox"/> 2 to 6 nights
<input type="checkbox"/> 1 week or more; but less than 1 month	<input type="checkbox"/> 1 month or more, but less than 90 days
<input type="checkbox"/> 90 days or more, but less than 1 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

**Clients enrolling in Emergency Shelter or Street Outreach OR clients coming from a HOMELESS SITUATION → Skip to Section 5**

**TRANSITIONAL AND PERMANENT HOUSING SITUATION**

Residential or halfway house with no homeless criteria

Hotel or motel paid for without emergency shelter voucher

Transitional Housing for Homeless Persons (including homeless youth)

Host Home (non-crisis)

Staying or living in a friend's room, apartment or house

Staying or living in a family member's room, apartment or house

Rental by client, with GPD TIP subsidy

Rental by client, with VASH housing subsidy

Permanent housing (other than RRH) for formerly homeless persons

Rental by client, with RRH or equivalent subsidy

Rental by client, with HCV voucher (tenant or project based)

Rental by client in a public housing unit

Rental by client, with no ongoing housing subsidy

Rental by client, with other ongoing housing subsidy

Owned by client, with ongoing housing subsidy

Owned by client, no ongoing housing subsidy

Client Doesn't Know

Client Refused

Data Not Collected

**4.2 | Stay less than 7 days?\***

No       Yes

**ANSWER THIS QUESTION ONLY IF "Yes" on Q.4.1 and 4.2**

**On the night before did you stay on the streets, ES, or SH?\***

Yes      Proceed to section 5 (below)

No      Proceed to section 6 (next page)

**5** History of Homelessness

**Approximate date homelessness started:**

\_\_\_\_\_

Record the actual or approximate date this homeless situation began (i.e. the beginning of the continuous period of homelessness on the streets, in ES, in SH, or moving back and forth between those places)

**(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"/> 1 time	<input type="checkbox"/> 2 times
<input type="checkbox"/> 3 times	<input type="checkbox"/> 4 or more times
<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
<input type="checkbox"/> Data not collected	

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

<input type="checkbox"/> One month (this time is the first month)	<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 months		
<input type="checkbox"/> Client Doesn't Know		<input type="checkbox"/> Client Refused
<input type="checkbox"/> Data Not Collected		

**6 Health Insurance:\***

<b>Covered by Health Insurance: *</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected

**If client has Health Insurance, check all that apply below:**


<input type="checkbox"/> Private	<input type="checkbox"/> State Children's Health Insurance Program S-CHIP
<input type="checkbox"/> Private - Employer	<input type="checkbox"/> Military Insurance
<input type="checkbox"/> Private - Individual	<input type="checkbox"/> State Funded
<input type="checkbox"/> Medicare	<input type="checkbox"/> Combined Children's Health Insurance/Medicaid Program
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Indian Health Service (IHS)
<input type="checkbox"/> Health insurance obtained through COBRA	<input type="checkbox"/> Other Public


**7 Connection with SOAR:\***


**P4 Connection with Soar?\***  Yes  No  Client Doesn't Know  Client Refused  Data Not Collected


**8 Barriers/Special Needs:\***


Identify whether a client has each individual barrier or not.  
Please select a status for each barrier, and if "Yes" is selected, answer follow-up question on the right.

<b>Alcohol Abuse*</b>	 If "Yes", answer this:	<b>Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?:</b>
<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Data Not Collected		<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Data Not Collected

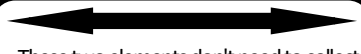
<b>Chronic Health Condition*</b>	 If "Yes", answer this:	<b>Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?:</b>
<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Data Not Collected		<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Data Not Collected

<b>Drug Abuse*</b>	 If "Yes", answer this:	<b>Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?:</b>
<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Data Not Collected		<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Data Not Collected

<b>Mental Health*</b>	 If "Yes", answer this:	<b>Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?:</b>
<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Data Not Collected		<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Data Not Collected

<b>Physical Disability*</b>	 If "Yes", answer this:	<b>Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?:</b>
<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Data Not Collected		<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Data Not Collected

<b>Developmental Disability*</b>
<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Data Not Collected

  
These two elements don't need to collect  
"Substantially impedes the individual's  
ability to live independently."

<b>HIV/AIDS*</b>
<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Data Not Collected

**Has the client been a victim of Domestic Violence?:\***

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

**If "Yes"**

**If "No" go to Section 10**

**When did the experience occur?**

- Within the past three months     Client Doesn't Know  
 Three to six months ago (excluding 6 months exactly)     Client Refused  
 Six months to one year ago (excluding 1 year exactly)     Data Not Collected  
 One year ago or more

**Is the client currently fleeing?:**

- Yes     No  
 Client Doesn't Know     Client Refused     Data Not Collected

**Income from any source:**

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

**Non-Cash Benefits from Any Source:\***

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

**Income Sources:**

**If client has income, check all that apply below, and record MONTHLY amount:**

- |  |   |
|--|---|
| <input type="checkbox"/> Earned Income (i.e., employment income)    \$* _____        | <input type="checkbox"/> General Assistance    \$* _____                  |
| <input type="checkbox"/> Unemployment Insurance    \$* _____                         | <input type="checkbox"/> Retirement income from Social Security \$* _____ |
| <input type="checkbox"/> Supplemental Security Income (SSI)    \$* _____             | <input type="checkbox"/> Veteran's Pension    \$* _____                   |
| <input type="checkbox"/> Social Security Disability Insurance (SSDI)    \$* _____    | <input type="checkbox"/> Other Pension    \$* _____                       |
| <input type="checkbox"/> Veteran's Disability Payment    \$* _____                   | <input type="checkbox"/> Child Support    \$* _____                       |
| <input type="checkbox"/> Private Disability Insurance    \$* _____                   | <input type="checkbox"/> Alimony or other spousal support    \$* _____    |
| <input type="checkbox"/> Worker's Compensation    \$* _____                          | <input type="checkbox"/> Other: _____ \$* _____                           |
| <input type="checkbox"/> Temporary Assistance for Needy Families (TANF)    \$* _____ |   |

**Non-Cash Benefit Sources:**

**If client receives non-cash benefits, check all that apply below:**

- Supplemental Nutrition Assistance Program (SNAP) (Food Stamps)    \$ \_\_\_\_\_     TANF Transportation Services  
 Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)     Other TANF-funded Services  
 TANF Child Care Services     Other Source (Specify: \_\_\_\_\_)

Identify the appropriate **Living Situation**

- Place not meant for habitation     Other  
 Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter.  
 Safe Haven     Worker unable to Determine