NJHMIS PATH Services Intake/Admission Form

***Intake Date**: ___/___/____ Client Location (Continuum of Care): {Pre-Populated}

Primary Worker: _____

*Information Sharing Level:

Referred By: To be determined after referral is created

* Indicates Required Fields

First Name:** _____Middle Name: _____Last Name**: _____

Suffix: _____ Alias _____

***Name Data Quality** (Select one): □Full name reported □Partial, street name, or code name reported

□Client doesn't know □Client refused □Data not collected

***Social Security Number:** ____/___/_____

***SSN Data Quality** :(select one)

□Full SSN Reported □Approximate or Partial SSN Reported □Client doesn't know □Client refused

□ Data not collected

***Gender**: (select one)

□Female □Male

□A gender that is not singularly 'Female' or 'Male'

□Transgender □Questioning

□Client doesn't know □Client refused □Data not collected

***Sexual Orientation:**

□Heterosexual □Gay □Lesbian □ Bisexual □Questioning/Unsure

□Other □Client doesn't know □Client refused □Data not collected

Birth Date: ___/____/_____

***Birth date Data Quality** :(select one)

□Full DOB Reported □Approximate or Partial DOB □Client doesn't know □Client refused

□Data not collected

***Ethnicity**: (select one) □Non-Hispanic/Non-Latin(a)(o)(x) □Hispanic/Latin(a)(o)(x)
□Client doesn't know □Client refused □Data not collected

***Race**: (select all that apply)

□American Indian/Alaska Native / or Indigenous □Asian or Asian American

□Black/African American, or African
□White
□Client refused
□Native Hawaiian/Pacific Islander
□Client doesn't know
□Data not collected

***Veteran Status**: (select one)

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

Prior Living Situation

***Type of Residence:** (select one)

-Homeless Situation-

□Place not meant for habitation (e.g., a vehicle, an abandoned building, bust/train subway station/airport or anywhere outside)

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

□Safe Haven

-Institutional Situations-

□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

-Temporary and Permanent Housing Situation-

□Residential project 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 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, 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

-Unknown Options-

□Client doesn't know

□Client refused

□Data not collected

***Length of stay in Prior Living Situation** (select one)

□One night or less □Two to six nights

□One week or more, but less than one month □One month or more, but less than 90 day's

□90 days or more, but less than one year □One year or longer

□Client doesn't know □Client refused

□Data not collected

Did you stay less than 7 nights? □No □Yes

***On the night before did you stay on the streets, ES or SH?** □No □Yes

***Approximate date homelessness 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:** (select one)

□One Time □Two Times □Three Times □Four or more 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**: (select one)

□One month (this time is the first month) □2 □3 □4 □5 □6 □7 □8

□9 □10 □11 □12 □More than 12 months □Client doesn't know □Client Refused

□Data not collected

Chronically Homeless (auto-calculated)

Current Living Situation:

-Homeless Situation-

□Place not meant for habitation (e.g., a vehicle, an abandoned building, bust/train subway station/airport or anywhere outside)

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

□Safe Haven

Unknown Options-

□Other

□Worker unable to determine

*__Income from any source:__ □No □Yes □Client doesn't know □Client refused □Data not collected

*__Monthly Income Sources:__ (select all that apply)

□Earned Income $_____

□SSI: $_____

□VA service-connected disability compensation $_____

□Private disability insurance $_____

□TANF $_____

□Retirement income from SSA $ _____

□Child Support $_____

□Other $_____

□Unemployment Insurance $_____

□SSDI $_____

□VA non-service-connected disability pension $_____

□Worker's compensation $_____

□General public assistance $_____

□Pension or retirement income from a former job $_____

□Alimony or other spousal support $_____

***Non-Cash Benefits from any source: (select one)**

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

*__Non-Cash Benefits__: (select all that apply)

□SNAP (Food Stamps) □Special Supplemental Nutrition Program for Women, Infants, &

Children (WIC)

□TANF Child Care services □TANF transportation services

□Other TANF-funded services □Section 8, public housing, or other ongoing rental assistance

□Temporary Rental Assistance □Other source: _____

***Covered by Health Insurance: (select one; if answer is yes please complete below)**

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

MEDICAID: □No □Yes MEDICARE: □No □Yes

State Children's Health Insurance program: □No □Yes

Veterans Administrations (VA) Medical Services: □No □Yes

Employer-Provided Health Insurance: □No □Yes

Health Insurance obtained through COBRA: □No □Yes

Private Pay Health Insurance No □Yes

State Health Insurance for Adults: □No □Yes

Indian Health Insurance: □No □Yes

Other: □No □Yes – Please specify: _____

Special Needs:

***Physical Disability (select one)**

□No □Yes □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? □No □Yes □Client doesn't know □Client refused □Data not collected

***Developmental Disability**: (select one)

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

***Chronic Health Condition:** (select one)

□No □Yes □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? □No □Yes □Client doesn't know □Client refused □Data not collected

***HIV/AIDS: (select one)**

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

***Mental Health Problem: (select one)**

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

(If client has a mental health problem) Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

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

***Substance Abuse: (select one)**

□No □Alcohol Abuse □Drug Abuse □Both Alcohol & Drug Abuse □Client doesn't know

□Client refused □Data not collected

(**If client has a substance abuse problem) Expected to of long-continued and indefinite duration and substantially impairs ability to live independently?**

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

Disabling Condition (auto-calculated)

Domestic Violence

***Information Date: _____**

***Domestic Violence Victim/Survivor**: (select one)

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

***(If Yes) When experience occurred: (select one)**

□Within the past three months □Client doesn't know

□Three to six months ago □Client refused

□From six to twelve months ago □Data not collected

□More than a year ago

***Are you currently fleeing? (select one)**

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

Engagement Date: ___/___/____

PATH STATUS:

Date of Status Determination: ____/____/____ **Client Became Enrolled in PATH**: □No □Yes

***Connection with SOAR: (select one)**

□No □Yes □Client doesn't know □Client Refused □Data not collected

Household Program Enrollment:

***Individual/Family Type:**

□Individual Male □Two Parent Family – Adult

□Individual Female □Two Parent Family – Youth

□Individual Male Youth (<18) □Adult Couple w/o Children

□Individual Female Youth (<18) □Household w/only Children

□Single Parent Family – Male Head □Other household type

□Single Parent Family – Female Head □Household member - adult

□Single Parent Family – Youth Head □Household member – child

Household Size _____

***Zip Code of Last Permanent Address: _____ (enter five 9's if they don't know zip code)**

Zip Code Data Quality: (select one)

□Full/Partial Zip Code Reported □Don't know □Refused

***Referral from Hospital: (select one)**

□State Hospital □County Hospital □Short-Term Care Facility/Involuntary Psychiatric Unit

□Other Hospital □Other Unknown □Not referred from Hospital

PATH Enrollment Status: (select one) □New Enrollee □Transfer

USTF Completed Date: ____/____/_____

Current Student: (select one)

□Yes □No □Don‘t know □Refused

Received vocational training or apprenticeship certificate: (select one)

□Yes □No □Don‘t know □Refused

***Marital Status:**

□Single □Married □Common Law □Divorced □Separated □Remarried □Widower □Civil Union

***Services Sought:**

□ Shelter/Housing □Drug Treatment □Mental Health Care □Medical Care □Legal Aid - CRJS/Civil

□Legal Aid – Immigration □Financial Assistance - Utilities □Financial Assistance – Housing □Financial

Assistance - Moving Expenses □Financial Assistance – Other □Other