PROJECTS FOR ASSISTANCE IN TRANSITIONING FROM HOMELESSNESS (PATH)

OUTREACH FORM

Date ________________ Person completing form: ____

Telephone number: ____________________ Fax: _______________

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Individual Information:

Name ____

Birth date __________________ **SSN** _____________ **Sex** _________ **Race** ____________________________

Ethnicity Non-Hispanic Hispanic

Veteran (circle one): YES NO	**Familial status (circle one):** Single Family
Jail/Prison last 12 months (circle one): YES NO	*If family please indicate how many members are in family: ________
Substance Abuse (circle one): YES NO	**Mental health diagnosis (circle one):** YES NO

Housing at first contact (**circle one**):			
Outdoors	Short-term shelter	Long-term shelter	Institution
Jail	Halfway house/ Residential TX	Own/someone else apt, room, etc.	Imminent risk of homelessness
Fleeing domestic violence	Client refused	Client does not know	Data not collected
Other (explain):			

Length of stay in previous place?___________

Length of time on street, in an emergency shelter (ES), or safe haven (SH)?____________

Number of days or months individual has been on street, ES, or SH in past 3 years?__________

Relationship to head of household?_______________

Source of income (head of household and adults)?_______________ Total monthly income?___________________

Non cash benefits? Y N Type of non cash benefits?____

Section 8, public housing, or ongoing rental assistance? Y N

Health insurance? Y N Type of health insurance?____

Disability? Y N Type of disability?____

Referrals provided:

☐ Community Mental Health ☐ Substance Abuse Treatment
☐ Primary Care ☐ Case Management
☐ Education assistance ☐ Relevant Housing services
☐ Income Assistance ☐ Housing Placement Assistance
☐ Employment Assistance ☐ Medical Assistance
☐ Job Training ☐ Other: ____
☐ SOAR

Services currently being received due to referral provided above:

- ◻ Community Mental Health
- ◻ Primary Care
- ◻ Education assistance
- ◻ Income Assistance
- ◻ Employment Assistance
- ◻ Job Training
- ◻ SOAR
- ◻ Substance Abuse Treatment
- ◻ Case Management
- ◻ Relevant Housing services
- ◻ Housing Placement Assistance
- ◻ Medical Assistance
- ◻ Other:______________________________________

To be completed by Core Service Agency staff

Amout of time spent: ________________

Client became enrolled in PATH? Y N

If no, reason not enrolled?____

Date of exit:___________________ Reason for exit:____

Destination after exit:____