

**Step 1: Basic Client Information**

Please complete the following basic client information and note that all fields with an \* are required fields. Universal Data Elements are required for all project participants. The response “Data Not Collected” means the question was not asked of the client and will report as missing on reports.

**Name Data Quality: \***

- Full Name Reported
- Partial, street name or code name reported
- Client doesn’t know
- Client prefers not to answer
- Data not collected

**Social Security Number: \***

- \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_
- Approximate or Partial SSN Reported
- Client doesn’t know
- Client prefers not to answer
- Data not collected

**Birthdate: \***

- Full DOB Reported
- Approximate or Partial DOB reported
- Client doesn’t know
- Client prefers not to answer
- Data not collected

**Race and Ethnicity: \***

- American Indian, Alaska Native, or Indigenous
- Asian or Asian American
- Black, African American, or African
- Hispanic/Latina/e/o
- Middle Eastern or North African
- Native Hawaiian or Pacific Islander
- White
- Client doesn’t know
- Client prefers not to answer
- Data not collected
- Additional Race and Ethnicity Detail:  
\_\_\_\_\_

**Gender: \***

- Woman (Girl if child)
- Man (Boy if child)
- Culturally Specific Identity (e.g., Two-Spirit)
- Transgender
- Non-Binary
- Questioning
- Different Identity
- Client doesn’t know
- Client prefers not to answer
- Data not collected

**Veteran Status: \***

- Yes
- No
- Client doesn’t know
- Client prefers not to answer
- Data not collected

**Pregnancy Status: \***

- Yes, Due Date: \_\_\_\_\_
- No                       Client doesn’t know
- Client prefers not to answer
- Data not collected

**Relationship to the Head of Household: \***

- Self                       Foster Child
- Son                         Grand Child
- Daughter                Other Family Member
- Dependent Child       Other Non-Family
- Spouse

Basic Client Information: \*

Address: \* \_\_\_\_\_ City/State/Zip: \* \_\_\_\_\_

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

Work Phone: \_\_\_\_\_ Msg Phone: \_\_\_\_\_

**Step 2: Program Enrollment**

Complete the project enrollment information and please note all fields with an \* are required fields. Complete additional forms for each household member enrolled.

Project Start Date: \* \_\_\_\_\_ Case Manager: \_\_\_\_\_

Project:

- PATH Street Outreach (**persons who generally reside in a place not meant for human habitation**)
- PATH Supportive Services Only (SSO) (**persons who generally reside in a place meant for human habitation or who are at risk of homelessness**)

Relationship to Head of Household \*:

- Self
- Foster Child
- Son
- Grand Child
- Daughter
- Other Family Member
- Dependent Child
- Other Non-Family
- Spouse

Client became enrolled in PATH	<i>(If Yes to Client became enrolled in PATH) Date PATH Status Determined</i>	<i>(If No to Client became enrolled in PATH) Reason not enrolled in PATH</i>	Date of Engagement
<input type="checkbox"/> Yes	___ / ___ / _____	<input type="checkbox"/> Client was found ineligible for PATH	___ / ___ / _____
<input type="checkbox"/> No		<input type="checkbox"/> Client was not enrolled for other reason(s)	
		<input type="checkbox"/> Unable to locate client	

**Step 3: Universal Data Assessment**

Complete the following entry assessments and please note all fields with an \* are required fields.

Disabling Condition: \*

- Yes
- Client doesn't know
- Data not collected
- No
- Client prefers not to answer

Enrollment CoC: \* IN-502 Indiana Balance of State

Living Situation

Identify the type of residence and length of stay at that residence just prior to (i.e., the night before) program admission.

Prior Living Situation: \*

**Homeless Situations**

- Place note meant for habitation (e.g., vehicle, abandoned building, bus/train/subway station/airport or anywhere outside)
- Emergency Shelter, including hotel or motel paid for with 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, juvenile detention facility
- Long-term care facility or nursing home
- Psychiatric hospital or other psychiatric facility
- Substance abuse treatment or detox center

**Temporary Housing Situations**

- Transitional housing for homeless persons (including homeless youth)
- Residential project or halfway house with no homeless criteria
- Hotel or Motel paid for without emergency shelter voucher
- 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

**Permanent Housing Situations**

- Rental by client, no ongoing housing subsidy
- Rental by client, with ongoing housing subsidy
- Owned by client, with ongoing housing subsidy
- Owned by client, no ongoing housing subsidy

**Other**

- Client doesn't know
- Client prefers not to answer

Length of stay in prior living situation: \*

- One night or less
- Two to six nights
- One week or more, but less than a month
- One month or more, but less than 90 days
- 90 days or more, but less than one year
- One year or more
- Client doesn't know
- Client prefers not to answer
- Data not collected

Approximate Date this episode of 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: \*

- One time
- Two times
- Three times
- Four or more times
- Client doesn't know
- Client prefers not to answer
- Data not collected

Health Insurance

Covered by Health Insurance: \*

- Yes
- Client doesn't know
- Data not collected
- No
- Client prefers not to answer

Type	Status	Reason No	
Private	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type n/a for this client	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
Private – Employer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type n/a for this client	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
Private – Individual	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type n/a for this client	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
Medicare	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type n/a for this client	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
Medicaid	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type n/a for this client	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
State Children's Health Insurance Program S-CHIP	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type n/a for this client	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
Military Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type n/a for this client	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
Other Public	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type n/a for this client	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected

Type	Status	Reason No
State Funded	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type n/a for this client <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
Combined Children's Health Insurance / Medicaid Program	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type n/a for this client <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
Indian Health Service (HIS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type n/a for this client <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
Other	<input type="checkbox"/> Yes If so, please specify: _____ <input type="checkbox"/> No	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type n/a for this client <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
Health Insurance obtained through COBRA	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type n/a for this client <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected

SOAR Connection Assessment: \*

Assessment Date: \* \_\_\_ / \_\_\_ / \_\_\_\_\_

Connection with SOAR: \*

- |                                              |                                                       |
|----------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Yes                 | <input type="checkbox"/> No                           |
| <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Client prefers not to answer |
| <input type="checkbox"/> Data not collected  |                                                       |

Barriers Assessment: \*

**Alcohol Use Disorder**

Barrier Present?

- Yes
- Client prefers not to answer
- No
- Data not collected
- Client doesn't know

Condition is Indefinite?

- Yes
- Client prefers not to answer
- No
- Data not collected
- Client doesn't know

**Mental Health**

Barrier Present?

- Yes
- Client prefers not to answer
- No
- Data not collected
- Client doesn't know

Condition is Indefinite?

- Yes
- Client prefers not to answer
- No
- Data not collected
- Client doesn't know

**Developmental Disability**

Barrier Present?

- Yes
- Client prefers not to answer
- No
- Data not collected
- Client doesn't know

Condition is Indefinite?

- Yes
- Client prefers not to answer
- No
- Data not collected
- Client doesn't know

**Physical Disability**

Barrier Present?

- Yes
- Client prefers not to answer
- No
- Data not collected
- Client doesn't know

Condition is Indefinite?

- Yes
- Client prefers not to answer
- No
- Data not collected
- Client doesn't know

**Drug Use Disorder**

Barrier Present?

- Yes
- Client prefers not to answer
- No
- Data not collected
- Client doesn't know

Condition is Indefinite?

- Yes
- Client prefers not to answer
- No
- Data not collected
- Client doesn't know

**Chronic Health Condition**

Barrier Present?

- Yes
- Client prefers not to answer
- No
- Data not collected
- Client doesn't know

Condition is Indefinite?

- Yes
- Client prefers not to answer
- No
- Data not collected
- Client doesn't know

**HIV/AIDS**

Barrier Present?

- Yes
- Client prefers not to answer
- No
- Data not collected
- Client doesn't know

Condition is Indefinite?

- Yes
- Client prefers not to answer
- No
- Data not collected
- Client doesn't know

Revised October 1, 2020

Domestic Violence Assessment: \*

Assessment Date: \* \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

Domestic Violence Experience:

- Yes  Client prefers not to answer
- No  Data not collected
- Client doesn't know

*If "Yes" to Domestic Violence Experience*

When Experience Occurred: \*

- Less than 3 months
- Between 3 months but less than 6 months
- Between 6 months but less than one year
- One year or more
- Client doesn't know
- Client prefers not to answer
- Data not collected

Currently Fleeing: \*

- Yes  Client prefers not to answer
- No  Data not collected
- Client doesn't know

Income and Sources, Non-Cash Benefits

Assessment Date: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_

Income from Any Source:

- Yes  Client prefers not to answer
- No  Data not collected
- Client doesn't know

*If "Yes" select all that apply*

<b>Type</b>	<b>Description</b>	<b>Monthly Amount</b>
<input type="checkbox"/> Earned Income		\$
<input type="checkbox"/> Private Disability Insurance		\$
<input type="checkbox"/> Unemployment Insurance		\$
<input type="checkbox"/> Worker's Compensation		\$
<input type="checkbox"/> Pension from a former job		\$
<input type="checkbox"/> Supplemental Security Income		\$
<input type="checkbox"/> Social Security Disability Income		\$
<input type="checkbox"/> Retirement (Social Security)		\$
<input type="checkbox"/> Alimony		\$
<input type="checkbox"/> Veteran's Pension		\$
<input type="checkbox"/> Veteran's Disability Payment		\$
<input type="checkbox"/> TANF		\$
<input type="checkbox"/> Child Support		\$
<input type="checkbox"/> Other Income		\$
<b>Count/Total Monthly Income:</b>		\$

Non-Cash Benefits from Any Source:

- Yes     
  Client prefers not to answer     
  Client doesn't know  
 No     
  Data not collected

*If "Yes" select all that apply*

<b>Type</b>	<b>Description</b>	<b>Monthly Amount</b>
<input type="checkbox"/> Food Stamps/Money for food on benefits card		\$
<input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children		\$
<input type="checkbox"/> TANF Child Care Services		\$
<input type="checkbox"/> TANF Transportation Services		\$
<input type="checkbox"/> Other TANF-funded Services		\$
<input type="checkbox"/> Other Source		\$
<b>Count/Total Monthly Income:</b>		\$

Expenses:

- Yes
- No
- Client doesn't know
- Client prefers not to answer
- Data not collected

If "Yes" to Expenses, select all that apply.

**Household**

Type	Description	Monthly Amount
<input type="checkbox"/> Rent		\$
<input type="checkbox"/> Mortgage		\$
<input type="checkbox"/> Maintenance		\$
	<b>Count/Total Monthly Income:</b>	\$

**Automotive**

Type	Description	Amount
<input type="checkbox"/> Car Payment		\$
<input type="checkbox"/> Car Insurance		\$
<input type="checkbox"/> Gasoline		\$
	<b>Count/Total Monthly Income:</b>	\$

**Food**

Type	Description	Monthly Amount
<input type="checkbox"/> Groceries		\$

**Other**

Type	Description	Monthly Amount
<input type="checkbox"/> Miscellaneous		\$

Current Living Situation Assessment: \*

Current Living Situation: \*

**Homeless Situations**

- Place not meant for habitation
- Emergency shelter, including hotel or motel paid for with emergency shelter voucher, host home shelter
- Safe Haven

**Other**

- Other
- Worker unable to determine

Record contact

Contact Service Information:

Contact Service:

- CE – Case Management
- PATH – Case Management
- PATH – Community Mental Health
- PATH – Contact
- PATH – Re-engagement
- PATH – Screening
- RHY – Contact

**Assessments**

- PATH – Housing Eligibility Determination

**Contact Service**

- ESG Outreach – Case Management
- ESG Outreach – Outreach
- ESG Outreach – Referral to Other Services

**Prevention/Outreach**

- ESG – Street Outreach

*Other helpful resources at <https://www.in.gov/ihcda/indiana-balance-of-state-continuum-of-care/hmis-clienttrack-and-dv-clienttrack/>*