PATH
Projects for Assistance in Transition from Homelessness

Contact/Services Form

1. Client Information

First Name____________________ **MI**______ **Last Name**____________________ **Suffix**______

If Name Not Known, Enter Description ______________________________

Relationship to HOH
- ☐ Self
- ☐ Spouse
- ☐ Dependent Child
- ☐ Parent
- ☐ Grandparent
- ☐ Guardian
- ☐ Other Family Member
- ☐ Other Non-family Member

Client ID (Computer Generated)____________________ **Last Four Digits of SS#, if Known** __________

2. Contact Summary

Date of Contact ______/______/______ **Time of Contact:** _____:_____ **AM / PM**

Staying on Streets, ES or SH ☐ No ☐ Yes ☐ Worker Unable to Determine

3. Services/Referrals Provided

Service/Referral Date: ______/______/______

Services Provided – PATH Funded	
Reengagement	☐
Screening	☐
Clinical Assessment	☐
Habilitation/rehabilitation	☐
Community mental health	☐
Substance use treatment	☐
Case management	☐
Residential supportive services	☐
Housing minor renovation	☐
Housing moving assistance	☐
Housing eligibility determination	☐
Security deposits	☐
One-time rent for eviction prevention	☐

Referrals Provided	
Community Mental Health	☐
Substance Use Treatment	☐
Primary Health/Dental Care	☐
Job Training	☐
Educational Services	☐
Housing Services	☐
Temporary Housing	☐
Permanent Housing	☐
Income Assistance	☐
Employment Assistance	☐
Medical Insurance	☐

Notes

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