**CT HMIS PATH/PSH/DMHAS/DDaP Discharge Form**

**Applicant (Head of Household) Information:**

**First Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Last Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Client ID#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Project End Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Case Manager Assigned to Discharge**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Household Member Name** |  | **Date of Birth** | **Sex:** 🞎 Male 🞎 Female 🞎 Client doesn’t know 🞎 Client Prefers Not to Answer 🞎 Data Not Collected | **Relationship to Head of Household** |
| **HMIS ID#** |
|  |  |  |  | **Self** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Cell Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_H**ome Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Work Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Housing Move – In Date:** ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Exit Destination Type:**

***HOMELESS SITUATION***

🞎 Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/

airport or anywhere outside)

🞎 Safe Haven

🞎 Psychiatric Hospital or other psychiatric facility

🞎 Substance Abuse treatment facility or detox center

🞎 Hospital or other residential non-psychiatric

medical facility

🞎 Jail, prison, or juvenile detention facility

🞎 Foster care or foster care group Home

🞎 Long-term care facility or Nursing Home

🞎 Transitional housing for homeless persons

(including homeless youth)

🞎 Rental by client, no ongoing housing subsidy

🞎 Owned by client, no ongoing housing subsidy

🞎 Staying or living with family, temporary tenure

(e.g., room, apartment or house)

🞎 Staying or living with friends, temporary tenure

(e.g., room, apartment or house)

🞎 Hotel or Motel paid for without Emergency Shelter voucher

🞎 Rental by client, with ongoing housing

Subsidy

**IF *Rental by client, with ongoing housing***

***Subsidy is Checked*, Please select Subsidy from List:**

🞎 *GPD TIP housing subsidy*

🞎 *VASH housing subsidy*

🞎 *RRH or equivalent subsidy*

🞎 *HCV voucher (tenant or project based) (not dedicated)*

🞎 *Public housing unit*

🞎 *Rental by client, with other ongoing housing subsidy*

🞎 *Emergency Housing Voucher*

🞎 *Family Unification Program Voucher (FUP)*

🞎 *Foster Youth to Independence Initiative (FYI)*

🞎 *Permanent Supportive Housing*

🞎 *Other permanent housing dedicated for formerly homeless persons*

🞎 Owned by client, with ongoing housing subsidy

🞎 Staying or living with family, permanent tenure

🞎 Staying or living with friends, permanent tenure

🞎 Moved from one HOPWA funded project to

HOPWA PH

🞎 Moved from one HOPWA funded project to

HOPWA TH

🞎 Residential Project or hallway house with no homeless criteria

🞎 Host Home (non-crisis)

------------------------------------------------------------

🞎 Other

🞎 Deceased

🞎 No exit interview completed

🞎 Client doesn't know

🞎 Client Prefers Not to Answer

🞎 Data Not Collected

If Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Shared Housing Information:**

*(Shared housing means clients will be on separate leases or living as roommates. Not clients living together as a couple)***:**

**Is this a Shared Housing Destination (separate leases)?** 🞎 Yes 🞎 No

***If Yes,***

**Shared Housing Facilitated by:?** 🞎 CAN 🞎 Client

**Non-Cash Benefit from any source?** 🞎 No 🞎 Yes 🞎 Client doesn’t know 🞎 Client Prefers Not to Answer🞎 Data Not Collected

*Non-cash benefits received by or on behalf of a minor child should be recorded as part of the household income under the Head of Household.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Head of Household** | **HH Member 2** | **HH Member 3** | **HH Member 4** | **HH Member 5** |
|  | **Check which applies** | **Check which applies** | **Check which applies** | **Check which applies** | **Check which applies** |
| (SNAP) Food Stamps | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Special Supplemental Nutrition Program for WIC | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| TANF Child Care Services | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| TANF Transportation | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Other TANF-Funded Services | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Client Doesn't know | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Client Refused | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Other (Please Specify): | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |

**Covered by Health Insurance:** 🞎 No 🞎 Yes 🞎 Client doesn’t know 🞎 Client Prefers Not to Answer🞎 Data Not Collected

**Connection with SOAR:** 🞎 No 🞎 Yes 🞎 Client doesn’t know 🞎 Client Prefers Not to Answer🞎 Data Not Collected

**Disabling Conditions (All Clients)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Head of Household** | **HH Member 2** | **HH Member 3** | **HH Member 4** | **HH Member 5** |
| **Disabling Condition** (All Adults) *No, Yes, Client Doesn’t Know, Client Prefers Not to Answer, Data Not Collected* | **N/A** |  |  |  |  |
| **Physical Disability** (All Clients)  *No, Yes, Client Doesn’t Know, Client Prefers Not to Answer, 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 Prefers Not to Answer, Data Not Collected* |  |  |  |  |  |
| **Developmental Disability** (All Clients)  *No, Yes, Client Doesn’t Know, Client Prefers Not to Answer, Data Not Collected* |  |  |  |  |  |
| **Chronic Health Condition** (All Clients)  *No, Yes, Client Doesn’t Know, Client Prefers Not to Answer, 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 Prefers Not to Answer, Data Not Collected* |  |  |  |  |  |
| **HIV/AIDS** (All Clients)  *No, Yes, Client Doesn’t Know, Client Prefers Not to Answer, Data Not Collected* |  |  |  |  |  |
| **Mental Health Disorder** (All Clients)  *No, Yes, Client Doesn’t Know, Client Prefers Not to Answer, 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 Prefers Not to Answer, Data Not Collected* |  |  |  |  |  |
| **Substance Abuse Disorder (**All Clients)  *No, Alcohol Disorder, Drug Disorder, Both Alcohol and Drug, Client Doesn’t Know, Client Prefers Not to Answer, Data Not Collected* |  |  |  |  |  |
| If yes, expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? *Yes, No, Client Doesn’t Know, Client Prefers Not to Answer, Data Not Collected* |  |  |  |  |  |

**Translation Assistance:**

**Translation Assistance Needed?** 🞎 Yes 🞎 No 🞎 Client doesn’t know 🞎 Client Prefers Not to Answer 🞎 Data Not Collected

*If yes,* Preferred Language*: ­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Health Insurance** (select which applies for each member)**:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Head of Household (HOH)** | **Member 2** | **Member 3** | **Member 4** | **Member 5** |
| 🞎 MEDICAID  🞎 MEDICARE  🞎 State Children’s Health Insurance Program  🞎 Veteran’s Health Administration (VHA)  🞎 Employer-Provided Health Insurance  🞎 Health Insurance obtained through COBRA  🞎 State Health Insurance for Adults  🞎 Private Pay Health Insurance  🞎 Indian Health Services Program  🞎 Other  If Other, Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎 MEDICAID  🞎 MEDICARE  🞎 State Children’s Health Insurance Program  🞎 Veteran’s Health Administration (VHA)  🞎 Employer-Provided Health Insurance  🞎 Health Insurance obtained through COBRA  🞎 State Health Insurance for Adults  🞎 Private Pay Health Insurance  🞎 Indian Health Services Program  🞎 Other  If Other, Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎 MEDICAID  🞎 MEDICARE  🞎 State Children’s Health Insurance Program  🞎 Veteran’s Health Administration (VHA)  🞎 Employer-Provided Health Insurance  🞎 Health Insurance obtained through COBRA  🞎 State Health Insurance for Adults  🞎 Private Pay Health Insurance  🞎 Indian Health Services Program  🞎 Other  If Other, Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎 MEDICAID  🞎 MEDICARE  🞎 State Children’s Health Insurance Program  🞎 Veteran’s Health Administration (VHA)  🞎 Employer-Provided Health Insurance  🞎 Health Insurance obtained through COBRA  🞎 State Health Insurance for Adults  🞎 Private Pay Health Insurance  🞎 Indian Health Services Program  🞎 Other  If Other, Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎 MEDICAID  🞎 MEDICARE  🞎 State Children’s Health Insurance Program  🞎 Veteran’s Health Administration (VHA)  🞎 Employer-Provided Health Insurance  🞎 Health Insurance obtained through COBRA  🞎 State Health Insurance for Adults  🞎 Private Pay Health Insurance  🞎 Indian Health Services Program  🞎 Other  If Other, Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Income**

**Income received from any source (HOH and Adults only)?** 🞎 No 🞎 Yes 🞎 Client doesn’t know 🞎 Client Prefers Not to Answer🞎 Data Not Collected

\*Note: *Income received by or on behalf of a minor child should be recorded as part of the household income under the Head of Household****.***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Head of Household** | **HH Member 1** | **HH Member 2** | **HH Member 3** |
| **Income Type** | **Monthly Amount** | **Monthly Amount** | **Monthly Amount** | **Monthly Amount** |
| Unemployment Insurance | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ |
| Earned/Employed Income | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ |
| Supplemental Security Income (SSI) | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ |
| Social Security Disability Insurance (SSDI) | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ |
| VA Service-Connected Disability Compensation | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ |
| Private Disability Insurance | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ |
| Retirement Income from Social Security | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ |
| General Assistance (GA) | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ |
| Temporary Assistance for Needy Families (TANF) | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ |
| VA Non-Service-Connected Disability Pension | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ |
| Pension or Retirement income from a former job | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ |
| Child Support | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ |
| Alimony or other spousal support | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ |
| Worker’s Compensation | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ |
| Other Source  Specify: | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ | 🞎 N 🞎 Y $ |
| CLIENT INCOME TOTAL: | $ | $ | $ | $ |

**HUD PATH Data**

**Date of Engagement: \_\_\_\_\_\_/\_\_\_\_\_\_ /\_\_\_\_\_\_ Date of PATH Status Determination: \_\_\_\_\_\_/\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_**  
**Client Became Enrolled in PATH?** 🞎 Yes 🞎 No   
IF “NO:” **Reason Not Enrolled?** 🞎 Client was found Ineligible for PATH 🞎 Client was not enrolled for other reason(s) 🞎 Unable to locate client

**DMHAS Specific Question** (\*= Required Information)**:**

**DMHAS Specific Questions** (\*= Required Information)**:**

**\*Discharge Reason**

🞎 AWOL for Inpatient only

🞎 Death

🞎 Evaluation Only

🞎 Incarcerated

🞎 Inpatient Discharge for Inpatient Medical Tx

🞎 Client Discontinued Tx

🞎 AMA

🞎 Left Against Advice

🞎 Moved out of area

🞎 Non-compliance with rules

🞎 Recovery Plan Completed

🞎 Released by Court

🞎 Discharged to New Service (Facility Concurs)

🞎 Other

🞎 Unknown

**\* Employment Status:**

🞎 Employed full time (in competitive employment)

🞎 Employed part time (in competitive employment)

🞎 Unemployed (looking for work in the past 30 days, or on a layoff)

🞎 Paid but non-competitive work (transitional employment programs)

🞎 Paid but non-competitive work (work inside the clubhouse or treatment agency, mobile work crews and consumer-run businesses)

🞎 Not in Labor Force: student enrolled in a school or job-training program

🞎 Not in Labor Force: homemaker

🞎 Not in Labor Force: retired

🞎 Not in Labor Force: SSI SSDI

🞎 Not in Labor Force: Inmate of institution.

🞎 Not in Labor Force: other reason

🞎 Other

🞎 Unknown

**\*Highest Grade Completed:**

🞎 (1- 32) #\_\_\_\_\_\_\_\_

🞎 Unknown

**Number of Persons Dependent on Income:**

(1 – 15) #\_\_\_\_\_\_\_\_

**Number of Minors Dependent on Income:**

(1 – 14) #\_\_\_\_\_\_\_\_

**\*Principle Income Source:**

🞎 Disability

🞎 None

🞎 Other

🞎 Public Assistance

🞎 Retirement

🞎 Salary

🞎 Unknown

**DMHAS - Insurance Type**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Insurance Type 1** | **Insurance Policy Number**  **(\*\*- REQUIRED)** | **Insurance Policy Start Date** | **Insurance Policy End Date** |
|  | **YES / NO\*** |  |  |  |
| No Health Insurance |  |  |  |  |
| Other private insurance |  |  |  |  |
| Medicare |  |  |  |  |
| Champus |  |  |  |  |
| \*\*Medicaid Husky C (***Insurance Policy Number Required)*** |  |  |  |  |
| HMO (including Managed Medicaid) |  |  |  |  |
| GA-SAGA |  |  |  |  |
| ATR-Access to Recovery |  |  |  |  |
| Self-Pay |  |  |  |  |
| Medicaid LIA Husky D |  |  |  |  |
| Medicare Part A |  |  |  |  |
| Medicare Part B |  |  |  |  |
| Money Follows the Person (MFP) |  |  |  |  |
| Nursing Home Waiver |  |  |  |  |
| \*\*Medicaid BHH (***Insurance Policy Number Required)*** |  |  |  |  |
| \*\*Medicaid- Husky A (***Insurance Policy Number Required)*** |  |  |  |  |
| Medicaid BHH - Waiver |  |  |  |  |
| Other |  |  |  |  |
| Unknown |  |  |  |  |

**Mental Health Diagnosis Assessment**

**Please provide ALL the ICD 10 Codes if Available and the Diagnosis:**

|  |  |  |  |
| --- | --- | --- | --- |
| AXIS I |  |  |  |
| AXIS I |  |  |  |
| AXIS I |  |  |  |
| AXIS II |  |  |  |
| AXIS II |  |  |  |
| AXIS III |  |  |  |
| AXIS III |  |  |  |
| AXIS III |  |  |  |
| AXIS IV |  |  |  |
| AXIS IV |  |  |  |
| AXIS IV |  |  |  |
| AXIS V |  |  | (GAF) |

**DSM Summary**

**Target symptoms being addressed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When under stress this client may:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If substance user, has client used in past 6 months?** 🞎 Yes 🞎 No

**The best way to respond:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date last used substance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current risk behaviors in last 6 months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Substance Abuse:**

**Currently Using:** 🞎 Yes 🞎 No **Last Used Date**: \_\_\_\_\_\_\_\_\_\_\_

**Frequency of use:**

🞎 Daily 🞎 Once or Twice a Week

🞎 Weekly 🞎 Monthly 🞎 Less than Monthly

**Currently in Treatment:** 🞎 Yes 🞎 No **Last Treatment Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sponsor Information:**

First Names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Longest Time abstinent**: Enter the numeric value and then select the term i.e. days, weeks, months, years

**Longest Time Free**: \_\_\_\_\_\_\_\_\_ (number)

**Measure of Longest Time Free**: 🞎 Day(s) 🞎 Week(s) 🞎 Month(s) 🞎 Year(s)

**Drug Information:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Primary Drug of Choice** | **Secondary Drug of Choice** | **Tertiary Drug of Choice** | **Forth Drug of Choice** | **Fifth Drug of Choice** |
| None |  |  |  |  |  |
| Amphetamines |  |  |  |  |  |
| Alcohol |  |  |  |  |  |
| Barbiturates |  |  |  |  |  |
| Benzodiazepines |  |  |  |  |  |
| Cocaine |  |  |  |  |  |
| Crack |  |  |  |  |  |
| Hallucinogens: LSD, DMS, STP, etc. |  |  |  |  |  |
| Heroin |  |  |  |  |  |
| Inhalants |  |  |  |  |  |
| Marijuana, Hashish, THC |  |  |  |  |  |
| Methamphetamines |  |  |  |  |  |
| Non-Prescriptive Methadone |  |  |  |  |  |
| Other Opiates and Synthetics |  |  |  |  |  |
| Other Sedatives or Hypnotics |  |  |  |  |  |
| Other Stimulants |  |  |  |  |  |
| Over-the-Counter |  |  |  |  |  |
| PCP |  |  |  |  |  |
| Tranquilizers |  |  |  |  |  |
| Other |  |  |  |  |  |
| Unknown |  |  |  |  |  |

**Method of Use:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Primary Drug of Choice Method of Use** | **Secondary Drug of Choice Method of use** | **Tertiary Drug of Choice Method of Use** | **Forth Drug of Choice Method of Use** | **Fifth Drug of Choice Method of Use** |
| Oral, |  |  |  |  |  |
| Smoking, |  |  |  |  |  |
| Inhalation, |  |  |  |  |  |
| Injection, |  |  |  |  |  |
| Other |  |  |  |  |  |
| Unknown |  |  |  |  |  |

**Number of days (last 30) in which client used the drug:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Primary Drug of Choice Last Use** | **Secondary Drug of Choice Last Use** | **Tertiary Drug of Choice Last Use** | **Forth Drug of Choice Last Use** | **Fifth Drug of Choice Last Use** |
| 0 to 30 Days |  |  |  |  |  |

**Age at which the client first used the Drug:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Primary Drug of Choice Age at First Use** | **Secondary Drug of Choice Age at First Use** | **Tertiary Drug of Choice Age at First Use** | **Forth Drug of Choice Age at First Use** | **Fifth Drug of Choice Age at First Use** |
| Age |  |  |  |  |  |

**Discharge Address (*Head of Household and All Adults*): *Required for DDaP***

**Address Data Quality:** 🞎 Full Address Reported 🞎 Incomplete or Estimated Address Reported 🞎 Client doesn’t know 🞎 Client Prefers Not to Answer

**Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Service Type:**

🞎 T1016 – Case Management with Client Face to Face

🞎 T116C – Case Management with Client B Y TELEPHONE

🞎 T116B – Case Management with Collateral

**Current Living Situation:** All street outreach projects are expected to ***record every contact made with each client by recording their Current Living Situation***, including when the Project Start Date, Prior Living Situation or Date of Engagement is recorded on the same day. There may or may not be a contact made at project exit.

**Information Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Project: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Living Situation:**

🞎 Emergency Shelter including hotel or motel paid for with Emergency Shelter voucher or RHY Funded Host Home Shelter

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

🞎 Safe Haven

🞎 Worker unable to determine

🞎 Other

**Location Details: ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Service Type:**

🞎 Adult Day Care

🞎 Alcohol or Drug Abuse Services

🞎 Alcohol or Drug Treatment

🞎 Assisted Housing (ES, TH, PSH)

🞎 Case Management

🞎 Child Care Assistance

🞎 Education (RHY)

🞎 Employment Skills Training

🞎 Health care

🞎 Housing Search and Info

🞎 Housing Services: Minor Renovation/repair

🞎 Housing Services: One-time rental payments

🞎 Housing Services: Security Deposits

🞎 Income Benefits

🞎 Legal Services

🞎 Life Skills (Outside of CM)

🞎 Meals (Breakfast/Lunch/Dinner/Sack Lunch)

🞎 Medical Insurance Plan

🞎 Mental Health

🞎 Mental Health Services

🞎 Mortgage Assistance

🞎 Moving Costs

🞎 Primary Medical Care

🞎 Referral

🞎 Rehabilitation

🞎 Rental Assistance

🞎 Screening and Diagnostics

🞎 Supportive and Supervisory services in residential

🞎 T1016 – Case Management with Client Face to Face

🞎 T116B – Case Management with Collateral

🞎 T116C – Case Management with Client B Y TELEPHONE

🞎 Transportation

🞎 Utility Assistance

**Additional notes:**