

ICA Missouri – PATH Start – SSO [FY2026]

Adult/HoH

Staff: _____ Project Start Date: ____/____/____ Name of Head of Household: _____

Project Name (Enter Data As): _____

i Unless specifically required by a funder, clients may use a preferred name (rather than legal name) for HMIS purposes.

Client Record

Name _____
First Middle Last Suffix

Name Data Quality ☐ Full Name Reported ☐ Partial, Street Name, or Code Name Reported
☐ Client doesn't know ☐ Client prefers not to answer

i Best practice is to collect all nine digits of the SSN for all clients; CoC-, ESG-, and PATH-funded projects are only required to attempt to collect the last four digits of the SSN. Other projects must attempt to collect all nine digits of the SSN, though clients can refuse all or part of the SSN. Unless explicitly requested by the client, the first five digits of the SSN should not be deleted if previously recorded in HMIS.

Social Security Number _____ - _____ - _____

☐ Full SSN Reported ☐ Approximate or Partial SSN Reported ☐ Client doesn't know ☐ Client prefers not to answer

U.S. Veteran ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

Client Profile Additional Information [Optional]

Contact Information _____

Emergency Contact _____

Current Living Situation

Date: ____/____/____

Current living situation (Where is the client staying right now?)

- ☐ Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/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
☐ Other (specify): _____
☐ Worker unable to determine

Date of Engagement

i Record the date of the first time the client expressed an interest in working together on a housing plan. This must be on or after the project start date. Leave blank if the client has not yet expressed an interest in working on a housing plan.

Date of Engagement ____/____/____

PATH Status

i Record the date on which the client's eligibility for PATH was determined, as well as the details about that determination. This date must be on or after the date of engagement. Leave blank if the client's eligibility for PATH has not yet been determined.

Date of Status Determination ____/____/____

Client Became Enrolled in PATH ☐ No ☐ Yes

If no, reason not enrolled
☐ Client was found ineligible for PATH
☐ Client was not enrolled for other reason(s)
☐ Unable to locate client

SSI/SSDI Outreach, Access, and Recovery (SOAR)

Connection with SOAR ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

Client Demographics

Date of Birth _____/_____/_____

☐ Full DOB Reported ☐ Approximate or Partial DOB Reported ☐ Client doesn't know ☐ Client prefers not to answer

Sex ☐ Female ☐ Male
☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

Race(s) and Ethnicity

select all that apply


- | | |
|--|--|
| <input type="checkbox"/> American Indian, Alaska Native, or Indigenous | <input type="checkbox"/> Asian or Asian American |
| <input type="checkbox"/> Black, African American, or African | <input type="checkbox"/> Hispanic/Latina/o |
| <input type="checkbox"/> Middle Eastern or North African | <input type="checkbox"/> Native Hawaiian or Pacific Islander |
| <input type="checkbox"/> White | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Client prefers not to answer | |

Additional Race & Ethnicity

optional, specify


Relationship to Head of Household ☐ Self ☐ Head of household's child
☐ Head of household's spouse or partner ☐ Other: non-relation member
☐ Head of household's other relation member (other relation to head of household)

Project CoC Code

 If you're unsure which CoC code to select for your project, reach out to the helpdesk for assistance.


Enrollment Location (CoC) ☐ MO-500 St. Louis County ☐ MO-501 St. Louis City
☐ MO-600 Springfield/Greene, Christian, Webster Counties ☐ MO-602 Joplin/Jasper, Newton Counties
☐ MO-603 St. Joseph/Andrew, Buchanan, DeKalb Counties ☐ MO-606 Missouri Balance of State

Client location as of assessment/review date

 Select the county in which the client is residing (or sleeping at night if unhoused). This field does not need to match the CoC Code above.

Client Location (County) _____

Last Permanent Address

 Record the last zip code the client had for at least 90 days that was not in an emergency shelter, a transitional housing project, a safe haven, or a place not meant for habitation.

Zip Code of Last Permanent Address _____

☐ Full or Partial Zip Code Reported ☐ Client doesn't know ☐ Client prefers not to answer

Disabilities

Disabling Condition ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

Health Insurance

Covered by Health Insurance ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

Medicaid (MO HealthNet)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Medicare	<input type="checkbox"/> No <input type="checkbox"/> Yes
State Children's Health Insurance Program	<input type="checkbox"/> No <input type="checkbox"/> Yes
Veteran's Health Administration	<input type="checkbox"/> No <input type="checkbox"/> Yes



HUD requires that the client be asked about each individual source of health insurance and requires an answer be recorded for each.

Employer-Provided Health Insurance	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Health Insurance obtained through COBRA	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Private Pay Health Insurance	<input type="checkbox"/> No	<input type="checkbox"/> Yes
State Health Insurance for Adults	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Indian Health Services Program	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Other (specify): _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes

①

Data Entry Tip:

Remember to end date old records and create new records each time a source of health insurance changes.

Monthly Income

Income from Any Source ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

Alimony and other spousal support	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Child support	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Earned income (i.e., employment income)	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
General Assistance (GA)	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Other (specify): _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Pension or retirement income from a former job	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Private disability insurance	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Retirement Income from Social Security	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Social Security Disability Insurance (SSDI)	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Supplemental Security Income (SSI)	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Temporary Assistance for Needy Families (TANF)	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Unemployment Insurance	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
VA Non-Service-Connected Disability Pension	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
VA Service-Connected Disability Compensation	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Worker's Compensation	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____

①

HUD requires that the client be asked about each individual source of income and requires an answer be recorded for each. For any income sources where income is received, the monthly amount must also be recorded.

①

Data Entry Tip:

Remember to end date old records and create new records each time a source of income changes.

Total Monthly Income \$ _____

Non-Cash Benefits

Non-Cash Benefits from Any Source ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

Supplemental Nutrition Assistance Program (SNAP) (Previously known as Food Stamps)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
TANF Child Care services	<input type="checkbox"/> No	<input type="checkbox"/> Yes
TANF transportation services	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Other TANF-funded services	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Other (specify): _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes

①

HUD requires that the client be asked about each individual source of non-cash benefits and requires an answer be recorded for each.

①

Data Entry Tip:

Remember to end date old records and create new records each time a source of non-cash benefit changes.

Chronic Homelessness Determination

Prior living situation (Where did the client stay immediately prior to entry?)

Homeless situations (if none of these options match, skip to "Institutional situations")

- ☐ Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)
- ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher, host home shelter
- ☐ Safe haven

Length of stay in homeless situation noted above

- | | |
|--|--|
| <input type="checkbox"/> One night or less | <input type="checkbox"/> 90 days or more, but less than one year |
| <input type="checkbox"/> Two to six nights | <input type="checkbox"/> One year or longer |

- ☐ One week or more, but less than one month
☐ One month or more, but less than 90 days
 Skip to "Approximate date homelessness started" (below)
- ☐ Client doesn't know
☐ Client prefers not to answer

Institutional situations (if none of these options match, skip to "Temporary housing 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

Length of stay in institutional situation noted above

- ☐ 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 days
- ☐ 90 days or more, but less than one year
☐ One year or longer
☐ Client doesn't know
☐ Client prefers not to answer

If you selected one of the underlined options above, were they on the streets or in emergency shelter prior to that? ☐ No ☐ Yes

If yes, skip to "Approximate date homelessness started" (below)

If no, skip to next section

Temporary housing situations (if none of these options match, skip to "Permanent housing situations")

- ☐ 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

Length of stay in temporary situation noted above

- ☐ 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 days
- ☐ 90 days or more, but less than one year
☐ One year or longer
☐ Client doesn't know
☐ Client prefers not to answer

If you selected one of the underlined options above, were they on the streets or in emergency shelter prior to that? ☐ No ☐ Yes

If yes, skip to "Approximate date homelessness started" (below)

If no, skip to next section

Permanent housing situations (if none of these options match, skip to "Other")

- ☐ Rental by client, no ongoing housing subsidy
☐ Rental by client, with ongoing subsidy (select subsidy type)
☐ Owned by client, with ongoing housing subsidy
☐ Owned by client, no ongoing housing subsidy

If "rental by client, with ongoing subsidy", select type

- ☐ GPD TIP housing subsidy
☐ VASH housing subsidy
☐ RRH or equivalent subsidy
☐ HCV Voucher (tenant or project based)
☐ Public housing unit
☐ Rental by client, with other ongoing housing subsidy
☐ Housing Stability Voucher
☐ Family Unification Program Voucher (FUP)
☐ Foster Youth to Independence Initiative (FYI)
☐ Permanent Supportive Housing
☐ Other permanent housing dedicated for formerly homeless persons

Length of stay in permanent situation noted above

- ☐ 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 days
- ☐ 90 days or more, but less than one year
☐ One year or longer
☐ Client doesn't know
☐ Client prefers not to answer

If you selected one of the underlined options above, were they on the streets or in emergency shelter prior to that? ☐ No ☐ Yes

If yes, skip to "Approximate date homelessness started" (below)

If no, skip to next section

Other

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

Skip to next section

Approximate date this episode of homelessness started: ____/____/____

Regardless of where they stayed last night, number of times on streets, in ES, or SH in the past 3 years including today

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> One time | <input type="checkbox"/> Three times | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Two times | <input type="checkbox"/> Four or more times | <input type="checkbox"/> Client prefers not to answer |

Total number of months homeless on the street, in ES, or SH in the past 3 years

- | | | | |
|---|----------------------------|-----------------------------|---|
| <input type="checkbox"/> One month (this time is the first month) | <input type="checkbox"/> 5 | <input type="checkbox"/> 9 | <input type="checkbox"/> More than 12 months |
| <input type="checkbox"/> 2 | <input type="checkbox"/> 6 | <input type="checkbox"/> 10 | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> 3 | <input type="checkbox"/> 7 | <input type="checkbox"/> 11 | <input type="checkbox"/> Client prefers not to answer |
| <input type="checkbox"/> 4 | <input type="checkbox"/> 8 | <input type="checkbox"/> 12 | |

Disabilities

- i** If one or more of the options below with an asterisk(*) has been selected, the answer to "disabling condition" must be "yes."
If none of the answers below with an asterisk(*) has been selected, the answer to "disabling condition" may be "yes" or "no."

Disability type	Disability determination	If yes, expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?
Alcohol Use Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA
Both Alcohol and Drug Use Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA
Chronic Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA
Developmental Disability	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	(not applicable)
Drug Use Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA
HIV/AIDS	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	(not applicable)
Mental Health Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA
Physical Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA

DK = Client doesn't know; Ref = Client prefers not to answer

Domestic Violence

- i** "Domestic violence" is utilized here as shorthand for domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions that relate to violence against the individual or a family member.

Survivor of Domestic Violence? ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

- If yes, when experience occurred
- | | |
|--|---|
| <input type="checkbox"/> Within the past three months | <input type="checkbox"/> Three to six months ago |
| <input type="checkbox"/> From six to twelve months ago | <input type="checkbox"/> More than a year ago |
| <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Client prefers not to answer |

If yes, currently fleeing? ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer