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 (Outreach Clients Only)

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

Location of Contact ☐ Place not meant for habitation ☐ Service setting, non-residential ☐ Service setting, residential

3. Services / Referrals Provided

Service / Referral Date: _____

Type of Service	Service Provided	Referral Provided
Case/care management	☐	☐
Consumer assistance and protection	☐	☐
Criminal justice/legal services	☐	☐
Day care	☐	☐
Education	☐	☐
Employment	☐	☐
Food	☐	☐
HIV/AIDS-related services	☐	☐
Housing Placement	☐	☐
Material Goods	☐	☐

Type of Service	Service Provided	Referral Provided
Mental health care/counseling	☐	☐
Other health care	☐	☐
Outreach	☐	☐
Personal enrichment	☐	☐
Referral to other service(s)	☐	☐
Substance abuse services	☐	☐
Temporary Housing & Other Financial Aid	☐	☐
Transportation	☐	☐
Other	☐	☐

Notes