



PATH PROGRAM REFERRAL FORM

PATH assists individuals who are experiencing homelessness **and** suffering from mental illness. If you or someone you know may benefit from this program, please **complete** the form below to your best knowledge.

Client Name: _____

Referring Agency: _____

SSN: _____

Client's Location: _____

Client Phone Number: _____

US. Military Veteran? Yes No

<i>Date of Birth</i>	<i>Gender</i>	<i>Race</i>	<i>Ethnicity</i>
	<input type="checkbox"/> Female	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Non-Hispanic/Non-Latino
	<input type="checkbox"/> Male	<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic/Latino
	<input type="checkbox"/> Trans Female	<input type="checkbox"/> Black/African American	
	<input type="checkbox"/> Trans Male	<input type="checkbox"/> Native Hawaiian/Other Pacific Islander	
	<input type="checkbox"/> Gender Non-Conforming	<input type="checkbox"/> White	

PATH Questions

Current Living Situation: Streets, Emergency Shelter Institution, Hospital, Other Housed but at risk of homelessness

Referral situation, useful background information:

What type of services are being sought?



Additional Information

Disabilities

Disabling Condition? Yes No Unknown

Disability Type

- Alcohol Abuse
- Drug Abuse
- Chronic Health Condition
- Developmental
- Mental Health Problem
- Physical Disability
- HIV/AIDS

Long-Continued & Indefinite Duration?

- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
- Yes No

Health Insurance

Active coverage? Yes No Unknown

- Medicaid
- Medicare
- State Children's Health Insurance Program
- VA Medical Services
- Employer-Provided Health Insurance

- Health Insurance obtained through COBRA
- Private Pay Health Insurance
- State Health Insurance for Adults
- Indian Health Services Program
- Other

Primary AK Regional Corp.

Is the client affiliated? Yes No Unknown

Secondary (if applicable):

- | | | |
|---|---|---|
| <input type="checkbox"/> Ahtna Corp. | <input type="checkbox"/> Calista Corp | <input type="checkbox"/> Koniag Incorp |
| <input type="checkbox"/> Aleut Corp. | <input type="checkbox"/> Chugach Alaska Corp | <input type="checkbox"/> NANA Regional Corp |
| <input type="checkbox"/> Arctic Slope Regional Corp | <input type="checkbox"/> Cook Inlet Regional Corp | <input type="checkbox"/> Sealaska |
| <input type="checkbox"/> Bering Straits Native Corp | <input type="checkbox"/> Doyon Limited Corp | <input type="checkbox"/> Descendant BIA Card Only |
| <input type="checkbox"/> Bristol Bay Native Corp | <input type="checkbox"/> Goldbelt | <input type="checkbox"/> Other |

Monthly Income

Does the client have a source of income? Yes No Unknown

Total Amount:	VA Non-Service Disability Pension	\$	Private Disability Insurance	\$
	VA Service Disability Compensation	\$	Earned Income	\$
	Worker's Compensation	\$	Pension/retirement from another job	\$
	Retirement Income From Social Security	\$	TANF	\$
	SSI	\$	Child Support	\$
	SSDI	\$	Alimony or Other Spousal Support	\$
	Unemployment Insurance	\$	General Assistance	\$
			Bristol Bay Native Corp	\$

Non-Cash Benefits

Does the client receive non-cash benefits? Yes No Unknown

- | | |
|--|---|
| <input type="checkbox"/> Supplemental Nutrition Assistance Program (Food Stamps) | <input type="checkbox"/> TANF Transportation Services |
| <input type="checkbox"/> Special Supplemental Nutrition Program for WIC | <input type="checkbox"/> TANF Child Care Services |
| <input type="checkbox"/> Other TANF-Funded Services | <input type="checkbox"/> Other Source |

If you/your referral is located at a camp or shelter and does not have a phone, please describe the location and identifying factors in the "referral situation" box.

Referrals can be turned in via email, fax, or directly to the CHOICES office.

If you have any questions about the referral process, please contact the PATH Program Manager @ 907-744-4534

Alternatively, email chalonl@choices-ak.org.