



Dear Potential Participant,

Attached you will find an application for the Continuum of Care (CoC) HUD funded program to be completed by you and the agency that is referring you to our program. In addition to completing this application, you will also need to provide:

- Documentation of a serious mental health disability [verification of disability form must be completed by a professional who, under the scope of their license, is able to diagnose]
- Authorization to Obtain and Release information (must be signed by referral party and applicant)
- A letter from referring party confirming homelessness according to HUD definition
- HALS CoC Funded Housing Programs Self Sufficiency Matrix

HUD Definition of Homeless – A person is considered homeless only when he/she resides in one of the places described below:

- Has a primary nighttime residence that is a public or private place not meant for human habitation. (ex: car, park, abandoned building, bus or train station, airport, camp ground)
- Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, **transitional housing for the homeless**, and hotels and motels **paid for by charitable organizations or by federal, state, and local government programs**); or
- Is exiting an institution, where he/she has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

Any individual or family who:

- Is fleeing, or is attempting to flee, domestic violence;
- Has no other residence; **and**
- Lacks the resources or support networks to obtain other permanent housing.

If you are still interested in this program it is important that we have all of these items as soon as possible.

We are considering several individuals for one opening. Therefore, it is important that each step of the process be handled in a thorough and efficient manner.

Please submit the completed application via email to Shannon Frey at shannon.frey@maryland.gov. Additionally, please feel free to call at (443) 523-1815 if you have any questions regarding this process.

Sincerely,

Shannon Frey

Continuum of Care (CoC) Lead



HALS COC FUNDED HOUSING PROGRAM INTAKE AND ASSESSMENT FORM

Date of Application: _____

Client Demographics: please note that bolded questions are required to be answered:

First Name: _____ **MI:** _____ **Last Name:** _____ **Suffix:** _____

Name Data Quality (all clients) Full name Partial, street name or code name reported
 Client doesn't know Client refused

Social Security #: _____ - _____ - _____ **Date of Birth:** ____/____/_____
 Full SSN reported Full date of birth reported
 Approx. or partial SSN reported Approx. or partial date of birth reported
 Client doesn't know Client doesn't know
 Client refused Client refused

Veteran Status (all adults) No Yes Client doesn't know Client refused

Primary & Secondary Race: (use P or S)
 American Indian/Alaska Native
 Asian
 Black/African American
 Native Hawaiian/Other Pacific Islander
 White
 Client doesn't know Client refused

Ethnicity (Check One):
 Hispanic/Latino
 Non-Hispanic/Non-Latino
 Client doesn't know
 Client refused

Gender (Check One):
 Male
 Female
 Transgender Male to Female
 Transgendered Female to Male
 Other _____ Client doesn't know Client refused

Does the client have a disabling condition? (Check One): Yes No

Residence Prior to Project Entry (Head of household and adults) (Check One):

- | | |
|--|--|
| <input type="checkbox"/> Emergency Shelter & motel paid by others | <input type="checkbox"/> Rental by client w/ VASH subsidy |
| <input type="checkbox"/> Foster Care Home or group home | <input type="checkbox"/> Rental by client, w /GPD TIP subsidy |
| <input type="checkbox"/> Hospital (non-psychiatric) | <input type="checkbox"/> Rental by client, w/other ongoing housing subsidy |
| <input type="checkbox"/> Hotel/Motel (w/o emergency shelter voucher) | <input type="checkbox"/> Residential /halfway house w/no homeless criteria |
| <input type="checkbox"/> Jail, prison or juvenile detention fac. | <input type="checkbox"/> Safe Haven |
| <input type="checkbox"/> Long Term care facility/nursing home | <input type="checkbox"/> Staying or living in family's room, apt. or house |
| <input type="checkbox"/> Owned by Client, no ongoing subsidy | <input type="checkbox"/> Staying or living in friend's room, apt. or house |
| <input type="checkbox"/> Owned by Client, with ongoing subsidy | <input type="checkbox"/> Substances abuse treatment facility or detox center |
| <input type="checkbox"/> Permanent housing (CoC project) | <input type="checkbox"/> Transitional homeless housing (incl. unacc. youth) |
| <input type="checkbox"/> Place not meant for Habitation | <input type="checkbox"/> Other (Describe) _____ |
| <input type="checkbox"/> Psychiatric hospital or other Psyc. Fac. | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Rental by client, no ongoing subsidy | <input type="checkbox"/> Client refused |

Length of Stay in Previous Place (head of household and adults):

- One day or less
- Two day to one week
- More than one week, but less than 1 month
- One to three months, but less than 1 year
- One year or longer
- Client doesn't know
- Client Refused

Relationship to Head of Household (all clients)

- Self (head of household)
- Head of Household Child
- Head of Household's spouse or partner
- Head of Household's other relative member (other relation to head of household)
- Other – non-relation member

Client Location (Head of Household) HUD assigned CoC Code - select MD-513

NEW QUESTIONS BELOW THAT REPLACE PREVIOUS QUESTIONS ON CHRONIC HOMELESSNESS

Length of Time on Street, in an Emergency shelter (ES), or Safe Haven (SH) (head of household and adults)

Client entering from Streets, ES or SH: No Yes Client doesn't know Client refused

If yes, for Client Entering from Streets, ES or SH, Approx. date started: _____

Regardless of where they stayed last night - # of times client has been on streets, ES or SH in past 3 years, including today: 0 1 2 3 4 5 6 7 8 9 10 11 12 More than 12 Client doesn't know Client refused

Total Number of Months homeless on the street, in ES or SH in the past 3 years? _____

Status Documented: No Yes

Total Monthly Income _____

Income And Sources (head of households and adults): No Yes Client doesn't know Client refused

Income: Source of Income (Check All that Apply) and list amounts for each :

- Alimony/Spousal Support _____
- Child support _____
- Earned income from job _____
- General Assistance (GA) _____
- Other specify source & amount _____
- Pension/Retirement from Former Job _____
- Private Disability Insurance _____
- Retirement Income from Social Security _____
- SSDI _____
- SSI _____
- TANF/TCA/TDAP _____
- Unemployment Insurance _____
- VA Non-Service Conn. Diab. Pension _____
- VA Service Conn Disab. Pension _____
- Workers Compensation _____

Non Cash benefits (head of household and adults): No Yes Client doesn't know Client refused

Non Cash Benefits (Check Yes on HMIS to all that apply. Answer No for benefits that have been terminated, even if they were received in the past). Amount of Non Cash Benefits \$ _____

- SNAP - Food Stamps
- Special Supplemental Nutritional Program for WIC
- TANF Child Care Services
- TANF Transportation Services
- Other TANF-Funded Services
- Section 8 Public Housing or Rental Assist.
- Temporary Rental Assistance, specify _____
- Other Source: _____

Health Insurance (all clients) – Covered by health Insurance: No Yes Client doesn't know Client refused

Health Insurance Benefits: (Check Yes on HMIS to all that apply. Answer No for benefits that have been terminated, even if they were received in the past).

- Medicaid
- Medicare
- State Children's Health Insurance Programs
- VA Medical Services
- Employer-Provided Health Insurance
- Health Insurance obtained through COBRA
- Private Pay Health Insurance
- State Health Insurance for Adults

Disability Type (Check All that Apply):

Alcohol Abuse No Yes Client doesn't know Client refused

If Yes, - Expected to be of long, continued, indefinite duration and substantially impairs ability to live independently

No Yes Client doesn't know Client refused

If Yes – Documentation of Disability and severity on file No Yes

Both Alcohol & Drug Abuse No Yes Client doesn't know Client refused

If Yes, - Expected to be of long, continued, indefinite duration and substantially impairs ability to live independently

No Yes Client doesn't know Client refused

If Yes – Documentation of Disability and severity on file No Yes

Chronic Health Condition No Yes Client doesn't know Client refused

If Yes, - Expected to be of long, continued, indefinite duration and substantially impairs ability to live independently

No Yes Client doesn't know Client refused

If Yes – Currently receiving services/treatment for this condition: No Yes Client doesn't know Client refused

Developmental No Yes Client doesn't know Client refused

If Yes, - Expected to be of long, continued, indefinite duration and substantially impairs ability to live independently

No Yes Client doesn't know Client refused

If Yes – Documentation of Disability and severity on file No Yes

If Yes – Currently receiving services/treatment for this condition: No Yes Client doesn't know Client refused

Drug Abuse No Yes Client doesn't know Client refused

If Yes, - Expected to be of long, continued, indefinite duration and substantially impairs ability to live independently

No Yes Client doesn't know Client refused

If Yes – Documentation of Disability and severity on file No Yes

If Yes – Currently receiving services/treatment for this condition: No Yes Client doesn't know Client refused

HIV/AIDS No Yes Client doesn't know Client refused

If Yes, - Expected to be of long, continued, indefinite duration and substantially impairs ability to live independently

No Yes Client doesn't know Client refused

If Yes – Documentation of Disability and severity on file No Yes

If Yes – Currently receiving services/treatment for this condition: No Yes Client doesn't know Client refused

Mental Health Problem No Yes Client doesn't know Client refused

If Yes, - Expected to be of long, continued, indefinite duration and substantially impairs ability to live independently

No Yes Client doesn't know Client refused

If Yes – Documentation of Disability and severity on file No Yes

If Yes – Currently receiving services/treatment for this condition: No Yes Client doesn't know Client refused

Physical No Yes Client doesn't know Client refused

If Yes, - Expected to be of long, continued, indefinite duration and substantially impairs ability to live independently

No Yes Client doesn't know Client refused

If Yes – Documentation of Disability and severity on file No Yes

If Yes – Currently receiving services/treatment for this condition: No Yes Client doesn't know Client refused

Is Client Domestic Violence Victim/Survivor? (Head of household and adults) No Yes Client doesn't know Client refused

If yes, when did the experience occur?

Within 3 months One year ago or more

3-6 months Client Doesn't Know

6 -12 months Client refused

If yes for domestic violence victim/survivor, are you currently fleeing?

No Yes Client doesn't know Client refused Data not collected

Household Information (children & spouse/significant others)

1.Name: _____ DOB: _____ SS#: _____
Gender: _____ Race: _____ Relationship to Applicant: _____
2.Name: _____ DOB: _____ SS#: _____
Gender: _____ Race: _____ Relationship to Applicant: _____
3.Name: _____ DOB: _____ SS#: _____
Gender: _____ Race: _____ Relationship to Applicant: _____
4.Name: _____ DOB: _____ SS#: _____
Gender: _____ Race: _____ Relationship to Applicant: _____

For any adults living in the household, complete the following:

Income And Sources (head of households and adults) : No Yes Client doesn't know Client refused

Income: Source of Income (Check All that Apply) and list amounts for each:

- Alimony/Spousal Support _____ SSDI _____
 Child support _____ SSI _____
 Earned income from job _____ TANF/TCA/TDAP _____
 General Assistance (GA) _____ Unemployment Insurance _____
 Other specify source & amount _____
 Pension/Retirement from Former Job _____ VA Non-Service Connected Diab. Pension _____
 Private Disability Insurance _____ VA Service Connected Disab. Pension _____
 Retirement Income from Social Security _____ Workers Compensation _____

Non Cash benefits (head of household and adults): No Yes Client doesn't know Client refused

Non Cash Benefits (Check Yes on HMIS to all that apply. Answer No for benefits that have been terminated, even if they were received in the past). Amount of Non Cash Benefits \$ _____

- SNAP - Food Stamps Other TANF-Funded Services
 Special Supplemental Nutritional Program for WIC Section 8 Public Housing or Rental Assist.
 TANF Child Care Services Temporary Rental Assistance, specify _____
 TANF Transportation Services Other Source: _____

Health Insurance (all clients) – Covered by health Insurance: No Yes Client doesn't know Client refused

Health Insurance Benefits: (Check Yes on HMIS to all that apply. Answer No for benefits that have been terminated, even if they were received in the past).

- Medicaid Employer-Provided Health Insurance
 Medicare Health Insurance obtained through COBRA
 State Children's Health Insurance Programs Private Pay Health Insurance
 VA Medical Services State Health Insurance for Adults

Disability No Yes Client doesn't know Client refused If adult, list disability type _____

Is Client Domestic Violence Victim/Survivor? (Head of household and adults) No Yes Client doesn't know
 Client refused If yes, are you currently fleeing? No Yes

If yes, when did the experience occur? Within 3 months 3-6 months 6 -12 months One year ago or more
 Client refused Client doesn't know

Mental Health:

Are you currently in treatment for mental health? Yes No
Treatment Start Date: _____ Treatment End Date: _____

If yes, list diagnosis. _____

Where are you currently being treated? _____

Have you ever been hospitalized for mental health issues? Yes No

If yes, please list location and date.

<i>Location</i>	<i>Treatment Start Date</i>	<i>Treatment End Date</i>

Are you currently on medication? Yes No

Do you take them as prescribed? Yes No

<i>Please list any current medications:</i>	<i>Dosage</i>	<i>Frequency</i>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Medical History:

Current Medical Issues: _____

Name of Primary Care Provider: _____

Address: _____ Phone: _____

<i>Please list any current medications:</i>	<i>Dosage</i>	<i>Frequency</i>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Substance Abuse:

Do you have a substance abuse history? Yes No

If yes, list drug(s) of choice: _____

How long were you actively engaged in substance abuse? _____ Months _____ Years

Substance Abuse Treatment History: (List Dates & Locations)
 Treatment Start Date: _____ Treatment End Date: _____

	<i>Location</i>	<i>Date</i>	<i>Location</i>	<i>Date</i>
A.A.				
N.A.				
Detox				
Inpatient				
Outpatient				

Has the applicant(s) ever been arrested for drug possession or distribution? Yes No

If yes, when? _____

Legal Information:

Are you on Probation? Yes No If yes, Probation Officer's Name: _____

Are you on Parole? Yes No If yes, Parole Officer's Name: _____

Current Warrant Issued? Yes No

Arrest Record:

Arrest Charge: _____	Were you convicted? <input type="checkbox"/> Yes <input type="checkbox"/> No
Arrest Date: _____	Did you serve time? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<i>If yes</i> , Prison or Jail? <input type="checkbox"/> Jail <input type="checkbox"/> Prison

Arrest Charge: _____	Were you convicted? <input type="checkbox"/> Yes <input type="checkbox"/> No
Arrest Date: _____	Did you serve time? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<i>If yes</i> , Prison or Jail? <input type="checkbox"/> Jail <input type="checkbox"/> Prison

Arrest Charge: : _____	Were you convicted? <input type="checkbox"/> Yes <input type="checkbox"/> No
Arrest Date: _____	Did you serve time? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<i>If yes</i> , Prison or Jail? <input type="checkbox"/> Jail <input type="checkbox"/> Prison

Are you a Convicted Sex Offender? Yes No

Additional Comments to Support Application

Emergency Contact: (Relative or friend's name and number who we can contact in the case of any emergency.)

Name: _____ Phone: _____

Referral Source: Must be completed.

Referring Party: _____	Date: _____
Agency: _____	
Type of Program: _____	
Agency Address: _____	
Agency Phone: _____	FAX: _____

Client's Statement:

All information that I have provided on this application is complete, truthful, and I have answered all questions to the best of my ability.

Client's Signature

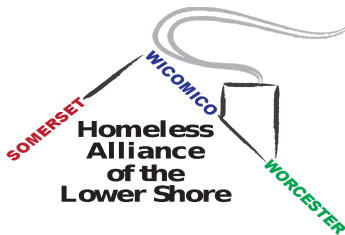
Date

Referral Checklist: (*Documentation below must be attached for completion of referral process.*)

- Documentation of Homelessness (Letter from referring agency stating homeless status of the client, or, if applicable, a letter from the Shelter.)
- Documentation of Disability (Letter from a doctor or other qualified professional that states this person has a disability.)
- Current Entitlements (Proof of any current entitlements being received, i.e. pay stubs, award letters, bank statements)
- Dually executed Consent to Release Information
- Self Sufficiency Matrix form

As the information contained in this application contains protected health information, please [email](#) this form to:

Shannon Frey, CoC Lead
shannon.frey@maryland.gov
Phone: (443) 523-1700



HALS CoC Funded Housing Programs
Verification of Disability
Authorization to Release Information

Continuum of Care Applicant: _____

I hereby authorize the release of the information requested below to the HALS CoC Funded Housing Program for the purpose of determining my eligibility for the Continuum of Care Housing Program.

CoC Applicant's Signature _____ Date _____

_____, has applied for housing through the HALS CoC Funded Housing Program. The Department of Housing and Urban Development's regulations governing the Continuum of Care Program requires verification of disability as a condition of participation in the program.

This release authorizes you to provide information regarding the physical/mental condition on the above applicant as follows:

1. Does the applicant have a diagnosis of Schizophrenia (DSM V 295.90, 295.40, 295.70, 295.80), Major Affective disorders (DSM V 296.33 and 296.34), Bipolar disorders (DSM V 296.43, 296.44, 296.53, 296.54, 296.40, 296.7, and 296.89), Delusional disorder (DSM V 297.1), Psychotic disorder (DSM V 298.8 and 298.9), Schizotypal Personality disorder (DSM V 301.22), and Borderline Personality disorder (DSM V 301.83), Post Traumatic Stress disorder (DSM V 309.81)

Yes: No: _____ Diagnosis and DSM V Code: _____

2. Has the applicant had the disability for two years or longer?

Yes: _____ No: _____ Date of Disability: _____

3. Is the disability expected to be of long- continued and indefinite duration?

Yes: No: _____

4. Would the nature of the applicant's disability be improved by more suitable housing conditions? Yes: _____ No: _____

Physician's Name: _____

Street Address: _____

City: State: _____ Zip Code: _____

Signature of Physician, Psychiatrist or
Licensed Professional

Phone Number

Date Completed



Homeless Alliance for the Lower Shore (HALS) Continuum of Care (CoC) Funded Projects

AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION

Homeless Clients' Personal Identifying Information:

Name: Birth Date: SSN:

Phone: Sex: Race:

Present Address:

Former Name (if applicable): _____

I authorize the following to obtain my personal information:

Name	Address	Phone Number
HALS CoC Funded Permanent Supportive Housing Programs (Tri-County Alliance for the Homeless PSH Programs and Wicomico, Somerset & Worcester County Shelter Plus Care Programs), City of Salisbury Housing Program, SSVF		

I request and authorize that the following personal information be provided:

- Mental Health
- Substance Related Abuse Treatment Information
- Communicable Disease information
- Disability Information
- X-Ray Reports
- Discharge Summary
- Shelter Stay
- Hospitalizations
- Other Health Care Information (Specify) Continuity of Care
- Other Personal (e.g. income, financial) information (Specify): program issues and emergency contact

Except for the following which expressly may NOT be disclosed (If none, write "NONE"):

If the information which a program has includes records or information from another entity, I DO or DO NOT wish to have that information released under this authorization. No service will be withheld if you do not authorize release of information attained by a program from another agency.

Conditions for Exchange of Authorized Information

Expiration: This authorization will expire two years from date below unless revoked in writing:

DATE / /

RIGHT TO REVOKE: I understand that I may revoke this authorization at any time by giving written notice in good faith. **(CRIMINAL JUSTICE SYSTEM REFERRALS – RULES:** “Revocation of consent” An individual whose release from confinement, probation, or parole is conditioned upon his participation in a treatment program may not revoke a consent given by him in accordance with paragraph (a) of this section until there has been a formal and effective termination or revocation of such release from confinement, probation or parole.” FEDERAL REGISTER, VOL 40, No 127, TUESDAY, July 1, 1975.)

USE SPACE BELOW ONLY IF CLIENT REVOKES CONSENT

□□/□□/□□□□

Date Consent Revoked by Client

Signature of Applicant

CONFIDENTIALITY: If the request for information concerns a person’s treatment of alcohol or drug abuse, the confidentiality of this information is protected by federal law: (42CFR Part 2) which prohibits any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A General Authorization for the release of medical or other information is NOT sufficient for this purpose.

REDISCLASURE: Any individual or agency receiving Homeless Alliance for the Lower Shore (HALS) CoC Funded Program applicant information is prohibited from making further disclosure of the medical record based on this authorization. This is prohibited as provided by the annotated Code of Maryland 4-303 (b) (5) (ii).

PHOTOSTAT/FACSIMILE: A Photostat or facsimile of this authorization is considered as effective and valid as the original.

Signature of Applicant

Date

Signature of Guardian or Legal Representative

Date

Relationship to Client: _____
(Attach copy of document granting legal authority)

Signature of Witness

Date

Signature of Counselor (if applicable)

Date



HALS CONTINUUM OF CARE HOUSING PROGRAM
Documentation of Homelessness

Please use the following space to have the applicant describe his or her current living situation. If currently in the detention center, please have them describe their living situation prior to incarceration. Their living situation prior to incarceration is required. Please use an additional sheet of paper as necessary.

Also, the referring agency must attach verification of current, or a history within the past 3 years or more of, applicant's homelessness from either the referring agency and/or a third party source if practical such as from an emergency shelter, emergency feeding program, DSS, HMIS, etc.

**** Verification of homelessness documentation must also be provided, using letterhead.**

Date: _____ Signed: _____

Date: _____ Witness: _____



HALS CoC Funded Housing Programs Self Sufficiency Matrix

Name: _____

Referring Agency: _____

Shelter/Housing Not Applicable

- 1. Homeless or threatened with eviction.
- 2. In transitional, temporary, or substandard housing; and/or current rent/mortgage payment is unaffordable (over 30% of income).
- 3. In stable housing that is safe but only marginally adequate,
- 4. Household is in safe, adequate, subsidized housing.
- 5. Household is in safe, adequate, unsubsidized housing.

Employment Not Applicable

- 1. No job.
- 2. Temporary, part-time or seasonal; inadequate pay, no benefits.
- 3. Employed full time; inadequate pay; few or no benefits.
- 4. Employed full time with adequate pay and benefits.
- 5. Maintains permanent employment with adequate income and benefits.

Income Not Applicable

- 1. No income.
- 2. Inadequate income and/or spontaneous or inappropriate spending.
- 3. Can meet basic needs with subsidy; appropriate spending.
- 4. Can meet basic needs and manage debt without assistance
- 5. Income is sufficient, well managed; has discretionary income and is able to save.

Food and Nutrition Not Applicable

- 1. No food or means to prepare it. Relies to a significant degree on other sources of free or low-cost food.
- 2. Household is on food stamps.
- 3. Can meet basic food needs, but requires occasional assistance.
- 4. Can meet basic needs without assistance.
- 5. Can choose to purchase any food household desires.

Child Care Not Applicable

- 1. Needs childcare, but none is available/ accessible and/or child is not eligible.
- 2. Childcare is unreliable or unaffordable, inadequate supervision is a problem for childcare that is available.
- 3. Affordable subsidized childcare is available, but limited.
- 4. Reliable, affordable childcare is available, no need for subsidies.
- 5. Able to select quality childcare of choice.

Children's Education Not Applicable

- 1. One or more school-aged children not enrolled in school.
- 2. One or more school-aged children enrolled in school, but not attending classes.
- 3. Enrolled in school, but one or more children only occasionally attending.
- 4. Enrolled in school and attending classes most of the time.
- 5. All school-aged children enrolled and attending on a regular basis.

Adult Education Not Applicable

- 1. Literacy problems and/or no high school diploma/GED are serious barriers to employment.
- 2. Enrolled in literacy and/or GED program and/or has sufficient command of English to where language is not a barrier to employment.
- 3. Has high school diploma/GED.
- 4. Needs additional education/training to improve employment situation and/or to resolve literacy problems to where they are able to function effectively in society.
- 5. Has completed education/training needed to become employable. No literacy problems.

Health Care Coverage Not Applicable

- 1. No medical coverage with immediate need.
- 2. No medical coverage and great difficulty accessing medical care when needed. Some household members may be in poor health.
- 3. Some members (e.g. Children) on Public Health Plan.
- 4. All members can get medical care when needed, but may strain budget.
- 5. All members are covered by affordable, adequate health insurance.

Life Skills Not Applicable

- 1. Unable to meet basic needs such as hygiene, food, activities of daily living.,
- 2. Can meet a few but not all needs of daily living without assistance.
- 3. Can meet most but not all daily living needs without assistance.
- 4. Able to meet all basic needs of daily living without assistance.
- 5. Able to provide beyond basic needs of daily living for self and family.

Family Relations Not Applicable

- 1. Lack of necessary support from family or friends; abuse (DV, child) is present or there is child neglect.
- 2. Family/friends may be supportive, but lack ability or resources to help; family members do not relate well with one another; potential for abuse or neglect.
- 3. Some support from family/friends; family members acknowledge and seek to change negative behaviors; are learning to communicate and support.
- 4. Strong support from family or friends. Household members support each other's efforts.
- 5. Has healthy/expanding support network; household is stable and communication is consistently open.

Mobility Not Applicable

- 1. No access to transportation, public or private; may have car that is inoperable.,
- 2. Transportation is available, but unreliable, unpredictable, unaffordable; may have car but no insurance, license, etc.
- 3. Transportation is available and reliable, but limited and/or inconvenient; drivers are licensed and minimally insured.
- 4. Transportation is generally accessible to meet basic travel needs.
- 5. Transportation is readily available and affordable, car is adequately insured.

Community Involvement Not Applicable

- 1. Not applicable due to crisis situation; in "survival" mode.
- 2. Socially isolated and/or no social skills and/or lacks motivation to become involved.
- 3. Lacks knowledge of ways to become involved.
- 4. Some community involvement (advisory group, support group), but has barriers such as transportation, childcare issues.
- 5. Actively involved in community.

Parenting Skills Not Applicable

- 1. There are safety concerns regarding parenting skills.
- 2. Parenting skills are minimal.
- 3. Parenting skills are apparent but not adequate.
- 4. Parenting skills are adequate.
- 5. Parenting skills are well developed.

Legal Not Applicable

- 1. Current outstanding tickets or warrants.
- 2. Current charges/trial pending, non-compliance with probation/parole.
- 3. Fully compliant with probation/parole terms.
- 4. Has successfully completed probation/parole within past 12 months, no new charges filed.
- 5. No active criminal justice involvement in more than 12 months and/or no felony criminal history.

Mental Health Not Applicable

- 1. Danger to self or others; recurring suicidal ideation; experiencing severe difficulty in day-to-day life due to psychological problems.,
- 2. Recurrent mental health symptoms that may affect behavior, but not a danger to self/others; persistent problems with functioning due to mental health symptoms.,
- 3. Mild symptoms may be present but are transient; only moderate difficulty in functioning due to mental health problems.
- 4. Minimal symptoms that are expectable responses to life stressors; only slight impairment in functioning.
- 5. Symptoms are absent or rare; good or superior functioning in wide range of activities; no more than everyday problems or concerns.

Substance Abuse Not Applicable

- 1. Meets criteria for severe abuse/dependence; resulting problems so severe that institutional living or hospitalization may be necessary.
- 2. Meets criteria for dependence; preoccupation with use and/or obtaining drugs/alcohol; withdrawal or withdrawal avoidance behaviors evident; use results in avoidance or neglect of essential life activities.
- 3. Use within last 6 months; evidence of persistent or recurrent social, occupational, emotional or physical problems related to use (such as disruptive behavior or housing problems); problems have persisted for at least one month.
- 4. Client has use during last 6 months, but no evidence of persistent or recurrent social, occupational, emotional, or physical problems related to use; no evidence of recurrent dangerous use.
- 5. No drug use/alcohol abuse in last 6 months.

Safety Not Applicable

- 1. Home or residence is not safe; immediate level of lethality is extremely high; possible CPS involvement.
- 2. Safety is threatened/temporary protection is available, level of lethality is high.
- 3. Current level of safety is minimally adequate; ongoing safety planning is essential.
- 4. Environment is safe, however, future of such is uncertain; safety planning is important.
- 5. Environment is apparently safe and stable.

Credit Not Applicable

- 1. Bankruptcies/Foreclosures/Evictions
- 2. Outstanding Judgements/Garnishments
- 3. Needs a Credit Repair Plan
- 4. Moderate Budgeting Skills
- 5. Manageable Budget and Ability to Save

Disabilities Not Applicable

- 1. In crisis - acute or chronic symptoms affecting housing, employment, social interactions, etc. always.
- 2. Vulnerable- sometimes has acute or chronic symptoms affecting housing, employment, social interactions, etc.
- 3. Safe - rarely has acute or chronic symptoms affecting housing, employment, social interactions, etc.,
- 4. Building Capacity - asymptomatic - condition may be controlled by services and/or medication.
- 5. Thriving - No identified disability.

Please submit the completed application via email to Shannon Frey at shannon.frey@maryland.gov