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):

( ) Emergency Shelter & motel paid by others
( ) Foster Care Home or group home
( ) Hospital (non-psychiatric)
( ) Hotel/Motel (w/o emergency shelter voucher)
( ) Jail, prison or juvenile detention fac.
( ) Long Term care facility/nursing home
( ) Owned by Client, no ongoing subsidy
( ) Owned by Client, with ongoing subsidy
( ) Permanent housing (CoC project)
( ) Place not meant for Habitation
( ) Psychiatric hospital or other Psyc. Fac.
( ) Rental by client, no ongoing subsidy
( ) Rental by client w/ VASH subsidy
( ) Rental by client,w /GPD TIP subsidy
( ) Rental by client,w/other ongoing housing subsidy
( ) Residential /halfway house w/no homeless criteria
( ) Safe Haven
( ) Staying or living in family's room, apt. or house
( ) Staying or living in friend's room, apt. or house
( ) Substances abuse treatment facility or detox center
( ) Transitional homeless housing (incl. unacc. youth)
( ) Other (Describe) _____
( ) Client doesn't know
( ) 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) _____
- ( ) SSDI_____
- ( ) SSI _____
- ( ) TANF/TCA/TDAP_____
- ( ) Unemployment Insurance
- ( ) Other specify source & amount _____
- ( ) Pension/Retirement from Former Job _____
- ( ) Private Disability Insurance _____
- ( ) Retirement Income from Social Security _____
- ( ) VA Non-Service Conn. Diab.Pension_____
- ( ) VA Service Conn Disab. Penson_____
- ( ) 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
3-6 months
6 -12 months
One year ago or more
Client Doesn't Know
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.

Location	***Treatment Start Date***	***Treatment End Date***

Are you currently on medication? ☐ Yes ☐ No Do you take them as prescribed? ☐ Yes ☐ No

Please list any current medications:	***Dosage***	***Frequency***
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. . _____	_____	_____

Medical History:

Current Medical Issues: _____

Name of Primary Care Provider: _____

Address:_____ Phone: _____

Please list any current medications:	***Dosage***	***Frequency***
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:

	Location	***Date***	***Location***	***Date***
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? ☐ Yes ☐ No

Arrest Date:_____ Did you serve time? ☐ Yes ☐ No
If yes, Prison or Jail? ☐ Jail ☐ Prison

Arrest Charge:_____ Were you convicted? ☐ Yes ☐ No

Arrest Date:_____ Did you serve time? ☐ Yes ☐ No
If yes, Prison or Jail? ☐ Jail ☐ Prison

Arrest Charge: :_____Were you convicted? ☐ Yes ☐ No

Arrest Date:_____ Did you serve time? ☐ Yes ☐ No
If yes, Prison or Jail? ☐ Jail ☐ 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.

REDISCLOSURE: 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: _____

Homeless Alliance of the Lower Shore

Participant Name _____ **DOB** ___/___/_____ **Assessment Date** ___/___/_____

Program Name _____ **Assessment Type:** ◉ **Initial** ○ **Interim** ○ **Exit**

Domain	0 *n/a*	1 *In Crisis*	2 *Vulnerable*	3 *Safe*	4 *Building Capacity*	5 *Empowered*	Score	Participant Goal? (✓)
Housing	*Response Required*	Homeless or threatened with eviction	In transitional, temporary, or substandard housing; and/or current rent/mortgage payment is unaffordable (over 30% of income)	In stable housing that is safe but only marginally adequate	Household is in safe, adequate, subsidized housing	Household is in safe, adequate, unsubsidized housing		☐
Employment	Not applicable	No job	Temporary, part-time or seasonal; inadequate pay, no benefits	Employed full time; inadequate pay; few or no benefits	Employed full time with adequate pay and benefits	Maintains permanent employment with adequate income and benefits		☐
Income	*Response Required*	No income	Inadequate income and/or spontaneous or inappropriate spending	Can meet basic needs with subsidy; appropriate spending	Can meet basic needs and manage debt without assistance	Income is sufficient, well managed; has discretionary income and is able to save		☐
Food/ Nutrition	*Response Required*	No food or means to prepare it; significant reliance on other sources of free or low-cost food	Household is on food stamps	Can meet basic food needs but requires occasional assistance	Can meet basic needs without assistance	Can choose to purchase any food household desires		☐
Child Care	Not applicable	Needs childcare, but none is available/accessible and/or child is not eligible	Childcare is unreliable or unaffordable; inadequate supervision is a problem for childcare that is available	Affordable subsidized childcare is available but limited	Reliable, affordable childcare is available; no need for subsidies	Able to select quality childcare of choice		☐
Children's Education	Not applicable	One or more school-aged children not enrolled in school	One or more school-aged children enrolled in school, but not attending classes	Enrolled in school, but one or more children only occasionally attending	Enrolled in school and attending classes most of the time	All school-aged children enrolled and attending on a regular basis		☐
Adult Education	*Response Required*	Literacy problem and/or no high school diploma or GED are serious barriers to employment	Enrolled in literacy program and/or GED and/or has sufficient command of English to the point where language is not a barrier to employment	Has high school diploma/GED	Needs additional education/ training to improve employment situation and/or to resolve literacy problems so they are able to function effectively in society	Has completed education/training needed to become employable; no literacy problems		☐
Health Care Coverage	*Response Required*	No medical coverage with immediate need	No medical coverage and great difficulty accessing medical care when needed; some household members may be in poor health	Some household members (e.g. children) on public health plan	All members can get medical care when needed, but may strain budget	All members are covered by affordable, adequate health insurance		☐
Life Skills	*Response Required*	Unable to meet basic needs such as hygiene, food, activities of daily living	Can meet a few but not all needs of daily living without assistance	Can meet most but not all daily living needs without assistance	Able to meet all basic needs of daily living without assistance	Able to provide beyond basic needs of daily living for self and family		☐
Family Relations	*Response Required*	Lack of necessary support from family or friends; abuse (DV, child) is present or there is child neglect	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	Some support from family/friends; family members acknowledge and seek to change negative behaviors; are learning to communicate and support	Strong support from family or friends; household members support each other's efforts	Has healthy/expanding support network; household is stable and communication is consistently open		☐

Homeless Alliance of the Lower Shore

Participant Name _____ **DOB** ____/____/_____ **Assessment Date** ____/____/_____

Program Name _____ **Assessment Type:** ◉ **Initial** ○ **Interim** ○ **Exit**

Domain	0 *n/a*	1 *In Crisis*	2 *Vulnerable*	3 *Safe*	4 *Building Capacity*	5 *Empowered*	Score	Participant Goal? (✓)
Mobility	*Response Required*	No access to transportation, public or private; may have car that is inoperable	Transportation is available but unreliable, unpredictable, unaffordable; may have car but no insurance, license, etc.	Transportation is available and reliable, but limited and/or inconvenient; drivers are licensed and minimally insured	Transportation is generally accessible to meet basic travel needs	Transportation is readily available and affordable, car is adequately insured		☐
Community Involvement	*Response Required*	Not applicable due to crisis situation; in "survival" mode	Socially isolated and/or no social skills and/or lacks motivation to become involved	Lacks knowledge of ways to become involved	Some community involvement (advisory group, support group) but has barriers such as transportation, childcare issues	Actively involved in community		☐
Parenting Skills	Not applicable	There are safety concerns regarding parenting skills	Parenting skills are minimal	Parenting skills are apparent but not adequate	Parenting skills are adequate	Parenting skills are well developed		☐
Legal	*Response Required*	Current outstanding tickets or warrants	Current charges/trial pending, non-compliance with probation/parole	Fully compliant with probation/parole terms	Has successfully completed probation/ parole within past 12 months, no new charges filed	No active criminal justice involvement in more than 12 months and/or no felony criminal history		☐
Mental Health	*Response Required*	Danger to self or others; recurring suicidal ideation; experiencing severe difficulty in day-to-day life due to psychological problems	Recurrent mental health symptoms that may affect behavior, but not a danger to self/others; persistent problems with functioning due to mental health symptoms	Mild symptoms may be present but are transient; only moderate difficulty in functioning due to mental health problems	Minimal symptoms that are expectable responses to life stressors; only slight impairment in functioning	Symptoms are absent or rare; good or superior functioning in wide range of activities; no more than everyday problems or concerns		☐
Substance Use and Addictive Behaviors	Not applicable	Meets criteria for severe abuse/dependence; resulting problems so severe that institutional living or hospitalization may be necessary	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	Use within last 6 months; evidence of persistent or recurrent social, occupational, emotional or physical problems related to use (e.g. disruptive behavior or housing problems); problems have persisted for at least one month	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	No drug use/alcohol abuse in last 6 months		☐
Safety	*Response Required*	Home or residence is not safe; immediate level of lethality is extremely high; possible CPS involvement	Safety is threatened / temporary protection is available; level of lethality is high	Current level of safety is minimally adequate; ongoing safety planning is essential	Environment is safe, however, future of such is uncertain; safety planning is important	Environment is apparently safe and stable		☐
Disabilities and Physical Health	Doesn't know/ declined to answer	Acute or chronic symptoms are currently affecting housing, employment, social interactions, etc.	Sometimes or periodically has acute or chronic symptoms affecting housing, employment, social interactions, etc.	Rarely has acute or chronic symptoms affecting housing, employment, social interactions, etc.	Asymptomatic; condition is controlled by services or medication	No identified disability or health concerns		☐