



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. (for example: car, park, abandoned building, bus or train station, airport, camp ground); or,
- 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 the listed 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 Sharon Creasy at [sharonr.creasy@maryland.gov](mailto:sharonr.creasy@maryland.gov).**

Additionally, please feel free to call 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

**Unaccompanied Homeless Youth? (under age 25)**  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. unaccompanied youth) |
| <input type="checkbox"/> Place not meant for Habitation              | <input type="checkbox"/> Other (Describe) _____                                    |
| <input type="checkbox"/> Psychiatric hospital or other psych. 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 days 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's 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. Dis. Pension \_\_\_\_\_
- VA Service Conn Dis. 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 Dis. Pension \_\_\_\_\_  
 Private Disability Insurance \_\_\_\_\_  VA Service-Connected Dis. 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: [sharonr.creasy@maryland.gov](mailto:sharonr.creasy@maryland.gov)**





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), Borderline Personality disorder (DSM V 301.83), or 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  
Relationship to Client: \_\_\_\_\_  
(Attach copy of document granting legal authority)

\_\_\_\_\_  
Date

\_\_\_\_\_  
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: \_\_\_\_\_



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? (✓)
<b>Housing</b>	<i>Response Required</i>	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		<input type="checkbox"/>
<b>Employment</b>	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		<input type="checkbox"/>
<b>Income</b>	<i>Response Required</i>	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		<input type="checkbox"/>
<b>Food/ Nutrition</b>	<i>Response Required</i>	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		<input type="checkbox"/>
<b>Child Care</b>	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		<input type="checkbox"/>
<b>Children's Education</b>	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		<input type="checkbox"/>
<b>Adult Education</b>	<i>Response Required</i>	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		<input type="checkbox"/>
<b>Health Care Coverage</b>	<i>Response Required</i>	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		<input type="checkbox"/>
<b>Life Skills</b>	<i>Response Required</i>	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		<input type="checkbox"/>
<b>Family Relations</b>	<i>Response Required</i>	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		<input type="checkbox"/>



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? (✓)
<b>Mobility</b>	<i>Response Required</i>	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		<input type="checkbox"/>
<b>Community Involvement</b>	<i>Response Required</i>	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		<input type="checkbox"/>
<b>Parenting Skills</b>	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		<input type="checkbox"/>
<b>Legal</b>	<i>Response Required</i>	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		<input type="checkbox"/>
<b>Mental Health</b>	<i>Response Required</i>	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		<input type="checkbox"/>
<b>Substance Use and Addictive Behaviors</b>	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		<input type="checkbox"/>
<b>Safety</b>	<i>Response Required</i>	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		<input type="checkbox"/>
<b>Disabilities and Physical Health</b>	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		<input type="checkbox"/>