



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**)
- Signed authorization to obtain and release information
- Signed and witnessed documentation of homelessness (according to HUD definitions listed below)
- 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, campground);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.

Additionally, please feel free to call 443-523-1700 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
 Approx. or partial SSN reported
 Client doesn't know
 Client refused

Full date of birth reported
 Approx. or partial date of birth reported
 Client doesn't know
 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.)
- Signed 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



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

Applicant Name: _____

I hereby authorize the release of information requested below to the Homeless Alliance for the Lower Shore (HALS) Continuum of Care (CoC) Funded Housing Program for the purpose of determining my eligibility for the program.

Applicant Signature: _____ **Date:** _____

The applicant named above has applied for housing through the HALS CoC-Funded Housing Program. The Department of Housing and Urban Development's (HUD) regulations governing the Continuum of Care program requires verification of disability as a condition of participation in this program.

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

1. Does the applicant have a diagnosis of:
 - a. Schizophrenia (F20.9, F20.81, F25.0, F25.1, F28, F29, F22)
 - b. Major Depression Disorders (F33.2, F33.3)
 - c. Bipolar Disorders (F31.13, F31.2, F31.4, F31.5, F31.0, F31.9, F31.81)
 - d. Schizotypal Personality Disorder (F21)
 - e. Borderline Personality Disorder (F60.3)

Yes **No** **If YES, please provide diagnosis and DSM V code:**

2. Has the applicant had the disability for two years or longer?
Yes **No** **If YES, date of disability diagnosis:** _____
3. Is the disability expected to be of long-continued or 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:** _____

x _____

Signature of Physician, Psychiatrist, or Licensed Professional

Phone Number: _____ **Date Completed:** _____



Somerset County Health Department

8928 Sign Post Road, Suite 2, Westover, Maryland 21871
443.523.1700 · Fax 410.651.5680 · TDD 1-800-735-2258

Health Officer: Danielle Weber, MS, RN

AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

*Use a separate form for each individual, program, organization or facility with which information may be shared.
Please type or print as clearly and completely as possible.*

1. Patient Name _____ Date of Birth _____

2. I hereby authorize and request the following party to release receive information:

Name of individual, program, organization or facility

address

3. to from the following party:

Name of individual, program, organization or facility

address

4. The following information (INITIAL all items covered by this authorization):

_____ Acknowledgement of receipt of services

_____ Complete Program record (includes all items below):

- | | | | |
|-----------------------------|--|----------------------------------|-----------------|
| _____ Intake assessment | _____ Treatment plan | _____ Progress notes | _____ Diagnosis |
| _____ History/Physical | _____ Lab Results | _____ Services/discharge summary | |
| _____ Medications | _____ Immunizations | _____ Identifying Information | |
| _____ Billing Records | _____ Photographs, Video, Digital or other images | | |
| _____ Mental health | _____ Records from other providers contained in the program record | | |
| _____ Other (specify) _____ | | | |

_____ Alcohol or other drug treatment records (requires specific authorization). Specify below.

_____ Complete record _____ Assessment results/history _____ Treatment/service plan
progress/compliance

_____ Other (specify) _____

5. The disclosure is for the following purpose(s) (Check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Patient request | <input type="checkbox"/> Treatment/continued care | <input type="checkbox"/> Review current care |
| <input type="checkbox"/> Payment | <input type="checkbox"/> Insurance application | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Other (please explain) _____ | | |

6. This authorization expires one year from the date the form is signed unless I indicate an earlier date or event (must occur sooner than 1 year from the date of my signature) here:

Until Date: _____ **OR** Until specific event: _____

7. I understand the following:

- a. By signing this form, I am authorizing that the health information specified in Section 4 be shared between the party named in section 2 and the party named in section 3.
- b. I may revoke this authorization at any time by writing to the individual(s), program(s), organization(s) or facility/facilities authorized to release information. If more than one individual, program, organization or facility has been authorized to release information, a written revocation request must be submitted to each party.
- c. If an individual, program, organization or facility has already released health information based on this authorization, revoking it will only prevent future disclosure by the party to whom a written revocation has been submitted.
- d. My treatment, payment for my treatment, enrollment or eligibility for services/benefits cannot be conditioned on the signing of this authorization, unless authorization is required to determine eligibility for services/benefits.
- e. The information disclosed may be subject to redisclosure by the recipient and no longer protected by HIPAA.

8. Patient Signature _____ **Date** _____

Parent or Person Representative _____ **Date** _____
Signature (if applicable)

If signed by Parent or Personal Representative, please indicate Relationship to Patient

- | | | |
|--|-----------------------------------|--|
| <input type="checkbox"/> Parent of Minor Child | <input type="checkbox"/> Guardian | <input type="checkbox"/> Authorized Representative |
| <input type="checkbox"/> Other _____ | | |

NOTICE

Any individual, program, organization or facility receiving information pursuant to this release is prohibited from redisclosing the information without the express, written consent of the patient. The information disclosed may be used only for the purpose(s) stated above.

If the information disclosed pursuant to this authorization contains information pertaining to alcohol or drug abuse treatment, diagnosis of alcohol or drug abuse or any referral for treatment of alcohol or drug abuse, 42 CFR Part 2 prohibits the unauthorized disclosure of these records.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the requested records.



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.

Date: _____ Applicant signature: _____

Date: _____ Witness signature: _____



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	<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"/>
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		<input type="checkbox"/>
Income	<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"/>
Food/ Nutrition	<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"/>
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		<input type="checkbox"/>
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		<input type="checkbox"/>
Adult Education	<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"/>
Health Care Coverage	<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"/>
Life Skills	<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"/>
Family Relations	<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? (✓)
Mobility	<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"/>
Community Involvement	<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"/>
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		<input type="checkbox"/>
Legal	<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"/>
Mental Health	<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"/>
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		<input type="checkbox"/>
Safety	<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"/>
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		<input type="checkbox"/>