Centralized or Coordinated Entry System – Assessment Tool

Attachment 1C-14 – CE Assessment Tool

Decatur/Macon County CoC

IL-516

Date: ___/___/_____
Staff Member _____
Agency/Engagement Point _____

Macon County Continuum of Care Engagement Point
Brief Assessment

Community Coordinated Entry
For Homeless or At-Risk Supports

The goal of this assessment is to coordinate and quickly connect individuals requesting services to available supports without bias. This may be done as a part of a program intake, or stand alone as an outreach effort, referral, or phone contact. You may use this form to collect the data, or another format which collects the same data in order to communicate it to outreach. All data points under BASIC INFO are required unless referred to DV.

Instructions: Please ask the following questions, marking the answers provided. If the individual needs an interpreter, please call HB outreach to complete the assessment over the phone using our Language Line.

1. Are you injured/sick/unsafe at this time? Y N
    a. If Yes. Do you need help contacting police/EMS? Y N
        i. If No. Go to question 2.
        ii. If Yes.
            1. Phone only - What is your current location and call back number if we get disconnected? _____, (___)___-_____
            2. Skip to demographics/contact question Basic Info and **call 911** for help keeping them on the line if possible.
    b. If No. Go to question 2.
2. What can we assist you with? _____
    a. If Housing/Shelter/place to stay. Go to question 3.
    b. If other non-housing, skip to Basic Info to capture information and then follow **individual agency referral process.**
3. Is anyone abusing or attempting to control or coerce you? Y N
    a. If yes. Connect to **217-423-2238 (24/7 Domestic Violence Hotline).**
    b. If no. Go to question 5.
4. Do you have a safe place to stay tonight? Y N
    a. If yes. Go to question Basic Info.
    b. If No. Are you looking for shelter because you are fleeing or escaping someone you were staying with/living with? Y N
        i. If yes. Connect to **217-423-2238 (24/7 Domestic Violence Hotline).**
        ii. If No. Go to question 5.
5. Do you have a relative or friend who could help you tonight? Y N
    a. If yes. complete Basic Info and **follow through to divert** If unable to divert ask again. This may take a few attempts.
    b. If no. go to question 6.
6. Is there anyone whom I could speak to on your behalf to help get/keep you off the street? Y N
    a. If yes. complete Basic Info and **follow through to divert** If unable to divert ask again. This may take a few attempts.
    b. If no. go to question Basic Info.

BASIC INFO

I'd like to get some basic information and contact someone at _____ on your behalf.
Do I have your permission to do that? Y N
Can I get just a few details? Y N

Name_____
DOB _____
Gender _____
Race/Ethnicity _____
Income/SNAP_____

Do you need help for an individual or family group?
IND FAM If family, how many? _____
Any member in household a Veteran? YES NO
Where can they contact you to follow up?
Location: _____
Phone: (_____) _____-_____

ALL HOUSING Call Homeward Bound Outreach to speak to **Outreach/Intake 217-362-7700,**
(After Hours: If Possible provide bed until the next business day, If not call **the after-hours line 217-619-5742**
ALL non-housing/diverted send basic info and outcome/referral to **outreach@doveinc.org**

Homeward Bound Program Intake Form

Application Date: _____ **Program Enrollment Date:** _____

Applicant (Head of Household) Information:

First Name: _____ **Last Name:** _____

Middle Name: _____ **Suffix:** _____

Name Data Quality: ☐ Full Name Reported ☐ Partial, Street Name, or Code Name reported ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected

Date of Birth: ____/____/____ ☐ Full DOB Reported ☐ Partial Month/Year ☐ Partial Day/Year ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected

Social Security Number: ___-___-___ ☐ Full SSN Reported ☐ Approximate or Partial SSN Reported ☐ Client Doesn't Know ☐ Client Refused

☐ Data Not Collected

Gender: ☐ Male ☐ Female ☐ Trans Female (MTF or Male to Female) ☐ Trans Male (FTM or Female to Male) ☐ Gender Non-Conforming (i.e. not exclusively male or female

☐ Client Doesn't Know ☐ Client Refused ☐ Transgender Unknown ☐ Transgender ☐ Unknown ☐ Data Not Collected

Primary Language: ☐ English ☐ Spanish ☐ French ☐ Portuguese ☐ Other ☐ Unknown If Other, please specify: _____

Race: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian/ Pacific Islander ☐ Client Doesn't Know ☐ Client Refused

☐ Data Not Collected

Ethnicity: ☐ Non-Hispanic or Latino ☐ Hispanic or Latino ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected

Highest Grade of Education Completed: ☐ _____ (K-8) ☐ High School ☐ Some College ☐ College Degree ☐ Client Doesn't Know ☐ Client refused ☐ Data Not Collected

Veteran Status: Have you ever been on active duty in the U.S. Military? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused ☐ Data Not Collected

Cell Phone: _____ **Home Phone:** _____ **Work Phone:** _____

Mailing Address: _____ **Email:** _____

Emergency Contact Name and Phone Number: _____

Prior Zip Code (Numbers Only): _____

Type of Residence (Residence Prior to Program entry):

HOMELESS SITUATION

☐ Emergency Shelter, including hotel or motel paid for with emergency shelter voucher
☐ Place not meant for human habitation
☐ Safe Haven
☐ Interim Housing

INSTITUTIONAL SITUATION

☐ Foster care home/foster care group home
☐ Hospital or other residential non-psychiatric medical facility
☐ Jail, prison, or juvenile detention facility
☐ Long-term care facility or nursing home
☐ Psychiatric hospital or other psychiatric facility
☐ Substance abuse treatment facility or detox center

TRANSITIONAL AND PERMAMENT HOUSING SITUATION

☐ Hotel or motel paid for w/o emergency shelter voucher
☐ Owned by client, no ongoing housing subsidy
☐ Owned by client, with ongoing housing subsidy
☐ Permanent housing (other than RRH) for formerly homeless persons
☐ Rental by client, no ongoing housing subsidy
☐ Rental by client, with other housing subsidy (including RRH)
☐ Staying or living in a family member's room, apartment/ house
☐ Staying or living in a friend's room, apartment or house
☐ Transitional housing for homeless persons (including homeless youth)
☐ Rental by client, with GPD TID subsidy
☐ Residential project or halfway house with no homeless criteria
☐ Client doesn't know
☐ Client refused
☐ Data Not Collected

Length of stay in the prior living situation

☐ One day or less
☐ Two days to one week
☐ More than one week, but less than one month
☐ One to three months
☐ More than three months, but less than one year
☐ One year or longer
☐ Client doesn't know
☐ Client refused
☐ Data Not Collected

Approximate date homelessness started: _____

(Regardless of where they stayed last night) Number of times the client has been on the streets, in Emergency Shelter, or Safe Haven in the past three years including today:

☐ Never in 3 years
☐ One Time
☐ Two Times
☐ Three Times
☐ Four or more times
☐ Client doesn't know
☐ Client refused
☐ Data Not Collected

Total number of months homeless on the streets, in Emergency Shelter, or Safe Haven in the past three years:

☐ One Month (this time is the first month)
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10
☐ 11
☐ 12
☐ More than 12 Months
☐ Client doesn't know
☐ Client Refused
☐ Data Not Collected

Domestic Violence Survivor? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused ☐ Data Not Collected

If "YES" When experience occurred?

☐ Within the past three months
☐ Three to six months ago (excluding six months exactly)
☐ Six months to one year ago (excluding one year exactly)
☐ One year ago, or more
☐ Client doesn't know
☐ Client refused
☐ Data Not Collected

If "YES" Are you currently fleeing? ☐ Yes ☐ No ☐ Don't Know ☐ Refused ☐ Data Not Collected

Household Demographics

Household Member	Date of Birth	Social Security Number	Gender	Relationship to Head of Household	Race/Ethnicity	Highest Grade in School (ALL)
1.						
2.						
3.						
4.						
5.						
6.						

Pregnancy Status for ANY Household Member: ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused **If "Yes:" Due Date** ____/____/____

Gender Categories:	Racial Categories:	Ethnicity
F = Female M = Male TF = Transgender female TM = Transgender male NI = Gender-nonconforming	AA = African American/Black AI = American Indian or Alaska Native AS = Asian H = Native Hawaiian/Pacific Islander MR = Multiple Races W = White	NH/NL = Non-Hispanic or Latino H/L = Hispanic or Latino

Income received from any source? ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

Income Type	Monthly Amount	Income Type	Monthly Amount
Unemployment Insurance	☐ N ☐ Y $	VA Non-Service-Connected Disability Pension	☐ N ☐ Y $
Earned/Employed Income	☐ N ☐ Y $	Pension or Retirement Income from a former job	☐ N ☐ Y $
Supplemental Security Income (SSI)	☐ N ☐ Y $	Child Support	☐ N ☐ Y $
Social Security Disability Insurance (SSDI)	☐ N ☐ Y $	Allmony or other spousal support	☐ N ☐ Y $
VA Service-Connected Disability Compensation	☐ N ☐ Y $	Worker's Compensation	☐ N ☐ Y $
Private Disability Insurance	☐ N ☐ Y $	Other Source, Specify:	☐ N ☐ Y $
Retirement Income From Social Security	☐ N ☐ Y $		
General Assistance (GA)	☐ N ☐ Y $		
Temporary Assistance for Needy Families (TANF)	☐ N ☐ Y $	Client Income Total	$

Non-cash benefit from any source? (All Clients) ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

Non-cash benefits received by or on behalf of a minor child should be recorded as part of the household income under Head of Household

	Head of Household	HH Member 1	HH Member 2	HH Member 3	HH Member 4
	YES/NO	YES/NO	YES/NO	YES/NO	YES/NO
(SNAP) Food Stamps					
Special Supplemental Nutrition Program for WIC					
TANF Childcare Services					
TANF Transportation					
Other TANF Funded Services					
Section 8, Public Housing or Rental Assistance					
Temporary Rental Assistance					
Client Doesn't Know					
Client Refused					
Other (Please Specify)					

Insurance

TYPE OF INSURANCE	YES/NO	IF NO (* Note: This is NOT Required, except for HOPWA Programs)
Medicaid		☐ applied; decision pending ☐ applied; client not eligible ☐ did not apply ☐ insurance type N/A ☐ client doesn't know ☐ client refused ☐ data not collected
Medicare		☐ applied; decision pending ☐ applied; client not eligible ☐ did not apply ☐ insurance type N/A ☐ client doesn't know ☐ client refused ☐ data not collected
State Children's Health Insurance Program (CHIP)		☐ applied; decision pending ☐ applied; client not eligible ☐ did not apply ☐ insurance type N/A ☐ client doesn't know ☐ client refused ☐ data not collected
Veterans Administration (VA) Medical Services		☐ applied; decision pending ☐ applied; client not eligible ☐ did not apply ☐ insurance type N/A ☐ client doesn't know ☐ client refused ☐ data not collected
Employer-Provided Health Insurance		☐ applied; decision pending ☐ applied; client not eligible ☐ did not apply ☐ insurance type N/A ☐ client doesn't know ☐ client refused ☐ data not collected
Health Insurance obtained through COBRA		☐ applied; decision pending ☐ applied; client not eligible ☐ did not apply ☐ insurance type N/A ☐ client doesn't know ☐ client refused ☐ data not collected
State Health Insurance for Adults		☐ applied; decision pending ☐ applied; client not eligible ☐ did not apply ☐ insurance type N/A ☐ client doesn't know ☐ client refused ☐ data not collected
Private Pay Health Insurance		☐ applied; decision pending ☐ applied; client not eligible ☐ did not apply ☐ insurance type N/A ☐ client doesn't know ☐ client refused ☐ data not collected
Indian Health Services Program		☐ applied; decision pending ☐ applied; client not eligible ☐ did not apply ☐ insurance type N/A ☐ client doesn't know ☐ client refused ☐ data not collected
Other (Specify)		☐ applied; decision pending ☐ applied; client not eligible ☐ did not apply ☐ insurance type N/A ☐ client doesn't know ☐ client refused ☐ data not collected

Disabling Condition (All Clients)

	Head of HH	HH 1	HH 2	HH 3	HH 4
Disabling Condition Yes, No, Client Doesn't Know, Client Refused					
Physical Disability Yes, No, Client Doesn't Know, Client Refused					
If yes, documentation of condition and severity on file Yes, No, Client Doesn't Know, Client Refused					
If yes, expected to be of indefinite duration AND impair ability to live independently Yes, No, Client Doesn't Know, Client Refused					
If yes, currently receiving services/treatment for condition Yes, No, Client Doesn't Know, Client Refused					
Developmental Disability Yes, No, Client Doesn't Know, Client Refused					
If yes, documentation of condition and severity on file Yes, No, Client Doesn't Know, Client Refused					
If yes, expected to be of indefinite duration AND impair ability to live independently Yes, No, Client Doesn't Know, Client Refused					
If yes, currently receiving services/treatment for condition Yes, No, Client Doesn't Know, Client Refused					
Chronic Health Condition Yes, No, Client Doesn't Know, Client Refused					
If yes, documentation of condition and severity on file Yes, No, Client Doesn't Know, Client Refused					
If yes, expected to be of indefinite duration AND impair ability to live independently Yes, No, Client Doesn't Know, Client Refused					
If yes, currently receiving services/treatment for condition Yes, No, Client Doesn't Know, Client Refused					
Mental Health Condition Yes, No, Client Doesn't Know, Client Refused					
If yes, documentation of condition and severity on file Yes, No, Client Doesn't Know, Client Refused					
If yes, expected to be of indefinite duration AND impair ability to live independently Yes, No, Client Doesn't Know, Client Refused					
If yes, currently receiving services/treatment for condition Yes, No, Client Doesn't Know, Client Refused					
Substance Use Disorder Yes, No, Client Doesn't Know, Client Refused					
If yes, documentation of condition and severity on file Yes, No, Client Doesn't Know, Client Refused					
If yes, expected to be of indefinite duration AND impair ability to live independently Yes, No, Client Doesn't Know, Client Refused					
If yes, currently receiving services/treatment for condition Yes, No, Client Doesn't Know, Client Refused					

☐ **Veteran Information Collected** ☐ **Not Applicable** ☐ **Data Not Collected**

DD214 Order Date: _____/_____/_____ **DD214 Receive Date:** _____/_____/_____

Service Connected Disability: ☐ Yes ☐ No

***Branch of military:** ☐ Air Force ☐ Army ☐ Marines ☐ Navy ☐ Coast Guard ☐ National Guard ☐ Air Guard ☐ Client Doesn't Know ☐ Client Refused ☐ Other

Reserves: ☐ Yes ☐ No

***Discharge status:** ☐ Honorable ☐ General under Honorable Conditions ☐ Under Other than Honorable Conditions ☐ Bad Conduct ☐ Dishonorable ☐ Uncharacterized ☐ Don't Know ☐ Refused

***Date Entered Service:** _____/_____/_____ ***Date Separated Service:** _____/_____/_____

Months of Active Duty: _____ **Campaign Badge Veteran:** ☐ Yes ☐ No

Stand Down Event: ☐ Yes ☐ No

Serve in a War Zone: ☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused

If YES, please select the **War Zone Name:** ☐ Afghanistan ☐ China, Burma, India ☐ Don't Know ☐ Europe ☐ Iraq ☐ Korea ☐ Laos and Cambodia ☐ North Africa
☐ Other ☐ Persian Gulf ☐ Refused ☐ South China Sea ☐ South Pacific ☐ Vietnam

***Months Served in a Warzone:** _____ ***If Yes, Received Friendly or Hostile Fire:** _____

***Theatre of Operations:** ☐ World War II ☐ Korean War ☐ Vietnam War ☐ Persian Gulf War (Operation Desert Storm) ☐ Afghanistan (Operation Enduring Freedom) ☐ Iraq (Operation Iraqi Freedom) ☐ Iraq (Operation New Dawn) ☐ Other Peace-keeping Operations or Military Intervention

Participant Signature: _____

Vulnerability Index -

Service Prioritization Decision Assistance Tool

(VI-SPDAT)

Prescreen Triage Tool for Single Adults

AMERICAN VERSION 2.0

1 (800) 355-0420 info@orgcode.com www.orgcode.com

COMMUNITY SOLUTIONS

Administration

Interviewer's Name	Agency	○ Team ○ Staff ○ Volunteer
_____	_____	
Survey Date	**Survey Time**	**Survey Location**
DD/MM/YYYY ___/___/_____	__ __ __ __	_____

Opening Script

Every assessor in your community regardless of organization completing the VI-SPDAT should use the same introductory script. In that script you should highlight the following information:

- the name of the assessor and their affiliation (organization that employs them, volunteer as part of a Point in Time Count, etc.)
- the purpose of the VI-SPDAT being completed
- that it usually takes less than 7 minutes to complete
- that only "Yes," "No," or one-word answers are being sought
- that any question can be skipped or refused
- where the information is going to be stored
- that if the participant does not understand a question or the assessor does not understand the question that clarification can be provided
- the importance of relaying accurate information to the assessor and not feeling that there is a correct or preferred answer that they need to provide, nor information they need to conceal

Basic Information

First Name	Nickname	Last Name	
_____	_____	_____	
In what language do you feel best able to express yourself? _____			
Date of Birth	**Age**	**Social Security Number**	**Consent to participate**
DD/MM/YYYY ___/___/_____	_____	_____	○ Yes ○ No

IF THE PERSON IS 60 YEARS OF AGE OR OLDER, THEN SCORE 1. **SCORE:** 0

A. History of Housing and Homelessness

1. Where do you sleep most frequently? (check one)

- ○ Shelters
- ○ Transitional Housing
- ○ Safe Haven
- ○ **Outdoors**
- ○ **Other (specify):** _____
- ○ **Refused**

IF THE PERSON ANSWERS ANYTHING OTHER THAN "SHELTER", "TRANSITIONAL HOUSING", OR "SAFE HAVEN", THEN SCORE 1.	SCORE: 1

2. How long has it been since you lived in permanent stable housing? ____ Years ☐ Refused

3. In the last three years, how many times have you been homeless? _____ ☐ Refused

IF THE PERSON HAS EXPERIENCED 1 OR MORE CONSECUTIVE YEARS OF HOMELESSNESS, AND/OR 4+ EPISODES OF HOMELESSNESS, THEN SCORE 1.	SCORE: 0

B. Risks

4. In the past six months, how many times have you...

a) Received health care at an emergency department/room? ____ ☐ Refused

b) Taken an ambulance to the hospital? ____ ☐ Refused

c) Been hospitalized as an inpatient? ____ ☐ Refused

d) Used a crisis service, including sexual assault crisis, mental health crisis, family/intimate violence, distress centers and suicide prevention hotlines? ____ ☐ Refused

e) Talked to police because you witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told you that you must move along? ____ ☐ Refused

f) Stayed one or more nights in a holding cell, jail or prison, whether that was a short-term stay like the drunk tank, a longer stay for a more serious offence, or anything in between? ____ ☐ Refused

IF THE TOTAL NUMBER OF INTERACTIONS EQUALS 4 OR MORE, THEN SCORE 1 FOR **EMERGENCY SERVICE USE.**	SCORE: 0

5. Have you been attacked or beaten up since you've become homeless? ☐ Y ☐ N ☐ Refused

6. Have you threatened to or tried to harm yourself or anyone else in the last year? ☐ Y ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **RISK OF HARM.**	SCORE: 0

7. Do you have any legal stuff going on right now that may result in you being locked up, having to pay fines, or that make it more difficult to rent a place to live? ☐ Y ☐ N ☐ Refused

IF "YES," THEN SCORE 1 FOR **LEGAL ISSUES.** SCORE: 0

8. Does anybody force or trick you to do things that you do not want to do? ☐ Y ☐ N ☐ Refused

9. Do you ever do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone you don't know, share a needle, or anything like that? ☐ Y ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **RISK OF EXPLOITATION.** SCORE: 0

C. Socialization & Daily Functioning

10. Is there any person, past landlord, business, bookie, dealer, or government group like the IRS that thinks you owe them money? ☐ Y ☐ N ☐ Refused

11. Do you get any money from the government, a pension, an inheritance, working under the table, a regular job, or anything like that? ☐ Y ☐ N ☐ Refused

IF "YES" TO QUESTION 10 OR "NO" TO QUESTION 11, THEN SCORE 1 FOR **MONEY MANAGEMENT.** SCORE: 0

12. Do you have planned activities, other than just surviving, that make you feel happy and fulfilled? ☐ Y ☐ N ☐ Refused

IF "NO," THEN SCORE 1 FOR **MEANINGFUL DAILY ACTIVITY.** SCORE: 0

13. Are you currently able to take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water and other things like that? ☐ Y ☐ N ☐ Refused

IF "NO," THEN SCORE 1 FOR **SELF-CARE.** SCORE: 0

14. Is your current homelessness in any way caused by a relationship that broke down, an unhealthy or abusive relationship, or because family or friends caused you to become evicted? ☐ Y ☐ N ☐ Refused

IF "YES," THEN SCORE 1 FOR **SOCIAL RELATIONSHIPS.** SCORE: 0

D. Wellness

15. Have you ever had to leave an apartment, shelter program, or other place you were staying because of your physical health?	☐ Y	☐ N	☐ Refused
16. Do you have any chronic health issues with your liver, kidneys, stomach, lungs or heart?	☐ Y	☐ N	☐ Refused
17. If there was space available in a program that specifically assists people that live with HIV or AIDS, would that be of interest to you?	☐ Y	☐ N	☐ Refused
18. Do you have any physical disabilities that would limit the type of housing you could access, or would make it hard to live independently because you'd need help?	☐ Y	☐ N	☐ Refused
19. When you are sick or not feeling well, do you avoid getting help?	☐ Y	☐ N	☐ Refused
20. *FOR FEMALE RESPONDENTS ONLY:* Are you currently pregnant?	☐ Y	☐ N	☐ N/A or Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **PHYSICAL HEALTH.** SCORE: 0

21. Has your drinking or drug use led you to being kicked out of an apartment or program where you were staying in the past?	☐ Y	☐ N	☐ Refused
22. Will drinking or drug use make it difficult for you to stay housed or afford your housing?	☐ Y	☐ N	☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **SUBSTANCE USE.** SCORE: 0

23. Have you ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of:

a) A mental health issue or concern?	☐ Y	☐ N	☐ Refused
b) A past head injury?	☐ Y	☐ N	☐ Refused
c) A learning disability, developmental disability, or other impairment?	☐ Y	☐ N	☐ Refused
24. Do you have any mental health or brain issues that would make it hard for you to live independently because you'd need help?	☐ Y	☐ N	☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **MENTAL HEALTH.** SCORE: 0

IF THE RESPONENT SCORED 1 FOR **PHYSICAL HEALTH** AND 1 FOR **SUBSTANCE USE** AND 1 FOR **MENTAL HEALTH**, SCORE 1 FOR **TRI-MORBIDITY.** SCORE: 0

25. Are there any medications that a doctor said you should be taking that, for whatever reason, you are not taking? ☐ Y ☐ N ☐ Refused

26. Are there any medications like painkillers that you don't take the way the doctor prescribed or where you sell the medication? ☐ Y ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR **MEDICATIONS.**	SCORE: 0

27. *YES OR NO:* Has your current period of homelessness been caused by an experience of emotional, physical, psychological, sexual, or other type of abuse, or by any other trauma you have experienced? ☐ Y ☐ N ☐ Refused

IF "YES", SCORE 1 FOR **ABUSE AND TRAUMA.**	SCORE: 0

Scoring Summary

DOMAIN	SUBTOTAL	RESULTS
PRE-SURVEY	0 /1	**Score: Recommendation:**
A. HISTORY OF HOUSING & HOMELESSNESS	1 /2	0-3: no housing intervention
B. RISKS	0 /4	4-7: an assessment for Rapid Re-Housing
C. SOCIALIZATION & DAILY FUNCTIONS	0 /4	8+: an assessment for Permanent Supportive Housing/Housing First
D. WELLNESS	0 /6	
GRAND TOTAL:	0 /17	

Follow-Up Questions

On a regular day, where is it easiest to find you and what time of day is easiest to do so?	place: _____ time: ___ : ___ or Night
Is there a phone number and/or email where someone can safely get in touch with you or leave you a message?	phone: (___) _____ - _____ email: _____
Ok, now I'd like to take your picture so that it is easier to find you and confirm your identity in the future. May I do so?	☐ Yes ☐ No ☐ Refused

Communities are encouraged to think of additional questions that may be relevant to the programs being operated or your specific local context. This may include questions related to:

- military service and nature of discharge
- ageing out of care
- mobility issues
- legal status in country
- income and source of it
- current restrictions on where a person can legally reside
- children that may reside with the adult at some point in the future
- safety planning

Family Service Prioritization Decision Assistance Tool

(F-SPDAT)

Assessment Tool for Families

VERSION 2.01

1 (800) 355-0420 info@orgcode.com www.orgcode.com

A. Mental Health & Wellness & Cognitive Functioning

PROMPTS	CLIENT SCORE:
• *Has anyone in your family ever received any help with their mental wellness?* • *Do you feel that every member in your family is getting all the help they need for their mental health or stress?* • *Has a doctor ever prescribed anyone in your family pills for nerves, anxiety, depression or anything like that?* • *Has anyone in your family ever gone to an emergency room or stayed in a hospital because they weren't feeling 100% emotionally?* • *Does anyone in your family have trouble learning or paying attention, or been tested for learning disabilities?* • *Do you know if, when pregnant with you, your mother did anything that we now know can have negative effects on the baby? What about when you were pregnant?* • *Has anyone in your family ever hurt their brain or head?* • *Do you have any documents or papers about your family's mental health or brain functioning?* • *Are there other professionals we could speak with that have knowledge of your family's mental health?*	**NOTES**

SCORING	
4	**Any** of the following among any family member: ☐ Serious and persistent mental illness (2+ hospitalizations in a mental health facility or psychiatric ward in the past 2 years) **and** not in a heightened state of recovery currently ☐ Major barriers to performing tasks and functions of daily living or communicating intent because of a brain injury, learning disability or developmental disability
3	**Any** of the following among any family member: ☐ Heightened concerns about state of mental health, but fewer than 2 hospitalizations, and/or without knowledge of presence of a diagnosable mental health condition ☐ Diminished ability to perform tasks and functions of daily living or communicating intent because of a brain injury, learning disability or developmental disability
2	While there may be concern for overall mental health or mild impairments to performing tasks and functions of daily living or communicating intent, **all** of the following are true: ☐ No major concerns about the family's safety or ability to be housed without intensive supports to assist with mental health or cognitive functioning ☐ No major concerns for the health and safety of others because of mental health or cognitive functioning ability ☐ No compelling reason for any member of the family to be screened by an expert in mental health or cognitive functioning prior to housing to fully understand capacity
1	☐ All members of the family are in a heightened state of recovery, have a Wellness Recovery Action Plan (WRAP) or similar plan for promoting wellness, understands symptoms and strategies for coping with them, **and** are engaged with mental health supports as necessary.
0	☐ No mental health or cognitive functioning issues disclosed, suspected or observed.

B. Physical Health & Wellness

PROMPTS	CLIENT SCORE:
• *How is your family's health?* • *Are you getting any help with your health? How often?* • *Do you feel you are getting all the care you need for your family's health?* • *Any illnesses like diabetes, HIV, Hep C or anything like that going on in any member of your family?* • *Ever had a doctor tell anyone in your family that they have problems with blood pressure or heart or lungs or anything like that?* • *When was the last time anyone in your family saw a doctor? What was that for?* • *Do you have a clinic or doctor that you usually go to?* • *Anything going on right now with your family's health that you think would prevent them from living a full, healthy, happy life?* • *Are there other professionals we could speak with that have knowledge of your family's health?* • *Do you have any documents or papers about your family's health or past stays in hospital because of your health?*	NOTES

SCORING	
4	**Any** of the following for any member of the family: ☐ Co-occurring chronic health conditions ☐ Attempting a treatment protocol for a chronic health condition, but the treatment is not improving health ☐ Pallative health condition
3	Presence of a health issue among any family member with **any** of the following: ☐ Not connected with professional resources to assist with a real or perceived serious health issue, by choice ☐ Single chronic or serious health concern but does not connect with professional resources because of insufficient community resources (e.g. lack of availability or affordability) ☐ Unable to follow the treatment plan as a direct result of homeless status
2	☐ Presence of a relatively minor physical health issue, which is managed and/or cared for with appropriate professional resources or through informed self-care ☐ Presence of a physical health issue, for which appropriate treatment protocols are followed, but there is still a moderate impact on their daily living
1	Single chronic or serious health condition in a family member, but **all** of the following are true: ☐ Able to manage the health issue and live a relatively active and healthy life ☐ Connected to appropriate health supports ☐ Educated and informed on how to manage the health issue, take medication as necessary related to the condition, and consistently follow these requirements.
0	☐ No serious or chronic health condition ☐ If any minor health condition, they are managed appropriately

C. Medication

PROMPTS	CLIENT SCORE:
• *Has anyone in your family recently been prescribed any medications by a health care professional?* • *Does anyone in your family take any medication, prescribed to them by a doctor?* • *Has anyone in your family ever had a doctor prescribe them a medication that wasn't filled or they didn't take?* • *Were any of your family's medications changed in the last month? Whose? How did that make them feel?* • *Do other people ever steal your family's medications?* • *Does anyone in your family ever sell or share their medications with other people it wasn't prescribed to?* • *How does your family store their medication and make sure they take the right medication at the right time each day?* • *What do you do if you realize someone has forgotten to take their medications?* • *Do you have any papers or documents about the medications your family takes?*	NOTES

	SCORING
4	**Any** of the following for any family member: ☐ In the past 30 days, started taking a prescription which **is** having any negative impact on day to day living, socialization or mood ☐ Shares or sells prescription, but keeps **less** than is sold or shared ☐ Regularly misuses medication (e.g. frequently forgets; often takes the wrong dosage; uses some or all of medication to get high) ☐ Has had a medication prescribed in the last 90 days that remains unfilled, for any reason.
3	**Any** of the following for any family member: ☐ In the past 30 days, started taking a prescription which is **not** having any negative impact on day to day living, socialization or mood ☐ Shares or sells prescription, but keeps **more** than is sold or shared ☐ Requires intensive assistance to manage or take medication (e.g., assistance organizing in a pillbox; working with pharmacist to blister-pack; adapting the living environment to be more conducive to taking medications at the right time for the right purpose, like keeping nighttime medications on the bedside table and morning medications by the coffeemaker) ☐ Medications are stored and distributed by a third-party
2	**Any** of the following for any family member: ☐ Fails to take medication at the appropriate time or appropriate dosage, 1-2 times per week ☐ Self-manages medications except for requiring reminders or assistance for refills ☐ Successfully self-managing medication for fewer than 30 consecutive days
1	☐ Successfully self-managing medications for more than 30, but less than 180, consecutive days
0	**Any** of the following is true for **every** family member: ☐ No medication prescribed to them ☐ Successfully self-managing medication for 181+ consecutive days

D. Substance Use

PROMPTS	CLIENT SCORE:
• *When was the last time you had a drink or used drugs? What about the other members of your family?* • *Anything we should keep in mind related to drugs/alcohol?* • *How often would you say you use [substance] in a week?* • *Ever have a doctor tell you that your health may be at risk because you drink or use drugs?* • *Have you engaged with anyone professionally related to your substance use that we could speak with?* • *Ever get into fights, fall down and bang your head, do things you regret later, or pass out when drinking or using other drugs?* • *Have you ever used alcohol or other drugs in a way that may be considered less than safe?* • *Do you ever drink mouthwash or cooking wine or hand sanitizer or anything like that?*	**NOTES**

Note: Consumption thresholds: 2 drinks per day or 14 total drinks in any one week period for men; 2 drinks per day or 9 total drinks in any one week period for women.

	SCORING
4	☐ An adult is in a life-threatening health situation as a direct result of substance use, **or**, ☐ Any family member is under the legal age but over 15 and would score a 3+, **or**, ☐ Any family member is under 15 and would score a 2+, **or** who first used drugs prior to age 12, **or**, In the past 30 days, **any** of the following are true for any adult in the family... ☐ Substance use is almost daily (21+ times) **and** often to the point of complete inebriation ☐ Binge drinking, non-beverage alcohol use, or inhalant use 4+ times ☐ Substance use resulting in passing out 2+ times
3	☐ An adult is experiencing serious health impacts as a direct result of substance use, though not (yet) in a life-threatening position as a result, **or**, ☐ Any family member is under the legal age but over 15 and would score a 2, **or**, ☐ Any family member is under 15 and would score a 1, **or** who first used drugs at age 13-15, **or**, In the past 30 days, **any** of the following are true for any adult in the family... ☐ Drug use reached the point of complete inebriation 12+ times ☐ Alcohol use usually exceeded the consumption thresholds (at least 5+ times), but usually not to the point of complete inebriation ☐ Binge drinking, non-beverage alcohol use, or inhalant use occurred 1-3 times
2	☐ Any family member is under the legal age but over 15 and would otherwise score 1, **or**, In the past 30 days, **any** of the following are true for any adult in the family... ☐ Drug use reached the point of complete inebriation fewer than 12 times ☐ Alcohol use exceeded the consumption thresholds fewer than 5 times
1	☐ In the past 365 days, no alcohol use beyond consumption thresholds, **or**, ☐ If making claims to sobriety, no substance use in the past 30 days
0	☐ In the past 365 days, no substance use