

ADMINISTRATION

Head of Household First Name:		Head of Household Last Name:	
Date:		Race/Ethnicity:	
Start Time:		Gender Identity (Male, Female, Transgender, Other):	
End Time:		Identifies as LGBTQ2+? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Survey Location - Shelter, Outreach, Drop In, or Other (specify):		Date of Birth:	
Previous VI-SPDAT completed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Ever served in the military? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Previous VI-SPDAT Score:		Pet(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2 nd Head of Household First Name:		2 nd Head of Household Last Name:	
Date:		Race/Ethnicity:	
Start Time:		Gender Identity (Male, Female, Transgender, Other):	
End Time:		Identifies as LGBTQ2+? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Survey Location - Shelter, Outreach, Drop In, or Other (specify):		Date of Birth:	
Previous VI-SPDAT completed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Ever served in the military? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Previous VI-SPDAT Score:		Pet(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Disclaimer:
 OrgCode Consulting, Inc. (OrgCode) cannot control the way in which the VI-SPDAT and SPDAT products will be used, applied or integrated by communities, agencies or frontline staff. OrgCode assumes no legal responsibility or liability for the decisions that are made or services that are received in conjunction with the tools.



OPENING SPEAKING POINTS

Cover the following in the opening explanation of the F-VI-SPDAT each time:

- The purpose of doing this triage with households that have children and are currently experiencing homelessness
- Some of the questions are personal in nature. It is their choice whether or not they want their children present, and if they do choose to have their children present, they can choose to skip questions that they don't want to answer in front of their children that we can try to come back to at the end or another time if someone can watch their children for a few minutes.
- Approximately how long it will take
- How to answer the questions (yes, no or simple one-word answers)
- That they can get clarification if they do not understand a question
- That they can skip or refuse to answer any question
- Where the information is stored
- The importance of being as honest as they feel comfortable being
- That some answers provided may need further verification from other sources (like whether or not they meet the definition of chronic homelessness)
- Consent to participate in the process

SECTION ONE: CHILDREN WITHIN THE HOUSEHOLD

1. How many children under the age of 18 are currently with you? _____
2. How many children under the age of 18 are not currently with your family, but you have reason to believe they will be joining you when you get housed? _____
3. Is any member of the family currently pregnant (*if applicable*)? Y N R
4. Please provide a list of children in your household:

Child 1 First Name:	Child 1 Last Name:
Child 1 Date of Birth:	Child 1 With Family?
Child 2 First Name:	Child 2 Last Name:
Child 2 Date of Birth:	Child 2 With Family?
Child 3 First Name:	Child 3 Last Name:
Child 3 Date of Birth:	Child 3 With Family?
Child 4 First Name:	Child 4 Last Name:
Child 4 Date of Birth:	Child 4 With Family?
Child 5 First Name:	Child 5 Last Name:
Child 5 Date of Birth:	Child 5 With Family?

Score 1 if any of the following conditions are met:

- If there is a single parent with 2+ children, and/or a child aged 11 or younger, and/or a current pregnancy.
- If there are two parents with 3+ children, and/or a child aged 6 or younger, and/or a current pregnancy.



SECTION TWO: PRESENTING NEEDS

5. Most days can you and your family:

- | | | | |
|--|----------------------------|----------------------------|----------------------------|
| a. Find a safe place to sleep | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> R |
| b. Access a bathroom when you need it | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> R |
| c. Access a shower when you need it | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> R |
| d. Get food | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> R |
| e. Get water or other non-alcoholic beverages to stay hydrated | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> R |
| f. Get clothing or access laundry when you need it | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> R |
| g. Safely store your stuff | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> R |

Score 1 if NO to Question 5 a, b, c, d, e, f or g.

SECTION THREE: HOUSING HISTORY & CHRONIC HOMELESSNESS DETERMINATION6. How long has it been since you and your family lived in stable, permanent housing? (*is this in days or months or years?*)

7. In the last three years, how many times have you been homeless?

8. IF THE ANSWER TO QUESTION 7 IS 2 OR MORE:

Thinking about those last three years and the different times you and your family were homeless, if you add up all the months you were homeless, what is the total length of time your family has experienced homelessness?

_____ months

9. Do you have any diagnosed, documented, disabling conditions?

 Y N R

Score 1 if YES to QUESTION 9 and the following conditions are met:

- *If the head of household:*
 - *experienced 1 or more consecutive years of homelessness or*
 - *4+ episodes of homelessness and the total duration of homelessness is 12+ months.*

10. Has your family ever lived in a home that you own or an apartment in your name? Y N R11. Have you and your family ever been evicted? Y N R

Score 1 if NO to Question 10 and/or YES to Question 11.



SECTION FOUR: VULNERABILITIES AND HOUSING SUPPORT NEEDS

12. In the last 6 months, how many times have you or anyone in your family: # of times
- a. Gone to the emergency room/department _____
 - b. Taken an ambulance _____
 - c. Been hospitalized as an inpatient _____
 - d. Used a crisis service or hotline for such concerns as family or intimate partner violence or suicide prevention _____
 - e. Talked to police because you witnessed a crime, were the victim of a crime, were the alleged perpetrator of a crime, or because they asked you to move along because of loitering, sleeping in a public place or anything like that _____
 - f. Stayed one or more nights in jail, a holding cell or prison _____

If the total number of interactions equals 4 or more, score 1.

13. Since your family has been homeless:
- a. Has anyone in your family been beaten up or assaulted Y N R
 - b. Has anyone in your family threatened to beat up or assault someone else Y N R
 - c. Has anyone in your family threatened to harm themselves or harmed themselves Y N R
 - d. Has anyone threatened you or anyone in your family with violence or made any of you feel unsafe Y N R
 - e. Has anyone tried to control you or anyone in your family through violence or threats of violence whether that be a stranger, friend, partner, relative or someone in your family Y N R

If YES to any of Question 13, score 1.

14. Does anyone in your family have any legal stuff going on right now that may result in any of the following:
- a. Being locked up Y N R
 - b. Having to pay fines or fees that you cannot afford Y N R
 - c. Impact your family's ability to get housing Y N R
 - d. Impact where you and your family could live in your housing Y N R
 - e. Impact your family's ability to stay together Y N R
15. Has anyone in your family ever been convicted of a crime that makes it difficult to access or maintain housing Y N R

If YES to any of Question 14 and/or YES to Question 15, score 1.



16. Does anyone trick, manipulate, exploit or force anyone in your family to do things they do not want to do? Y N R

17. Where do you and your family sleep most frequently? (*select one response*)

- Shelters Transitional Housing Couch Surfing
- Outdoors Car Other _____

18. Does anyone in your family ever do things that may be considered to be risky or harmful like run drugs, share a needle, do sex work, or anything like that? Y N R

Score 1 if any of the following conditions are met:

- YES to Question 16;
- If the family stays any place other than Shelters or Transitional Housing in Question 17;
- YES to Question 18.

19. Is there anybody that thinks that you or anyone in your family owes them money like a family member, friend, past landlord, business, bookie, dealer, bank, credit card company, utility company or anyone like that? Y N R

20. Do you or anyone in your family get any money from the government, a job, alimony, child support, working under the table, day labour, an inheritance or a pension, or anything like that? Y N R

21. Do you or anyone in your family ever gamble with money they cannot afford to lose or have debts associated with gambling? Y N R

Score 1 if any of the following conditions are met:

- YES to Question 19;
- NO to Question 20;
- YES to Question 21.

22. Does everyone in your family have planned activities, other than activities for survival, at least four days per week that make them feel happy and fulfilled? Y N R

If NO to Question 22, score 1.

23. Does your family have a collection of belongings that gets in the way with your ability to access services or housing? Y N R

If YES to Question 23, score 1.

24. Would you say that your family’s current homelessness was caused by any of the following:

- a. A relationship that broke down Y N R
- b. An unhealthy or abusive relationship Y N R
- c. Because family or friends caused your family to lose your housing Y N R



25. Do most of your family and friends have stable housing? Y N R

If YES to any of Question 24, and/or NO to Question 25, score 1.

26. Is anyone in your current household 60 years of age or older? Y N R

27. Does anyone in your family have any physical or mental health issues or cognitive issues including a brain injury, that might require assistance to access or keep housing? Y N R

If YES to Question 26 and/or YES to Question 27, score 1.

28. Does anyone in your family use alcohol or drugs in a way that it:
- a. Impacts their life in a negative way most days Y N R
 - b. Makes it hard to access housing Y N R
 - c. Might require assistance to maintain housing Y N R

If YES to any of Question 28, score 1.

29. Are there any medications that, for whatever reason:
- a. A doctor said someone in your family should be taking but they are not taking Y N R
 - b. The medication gets sold instead of being taken Y N R
 - c. The medication is used other than how it is prescribed Y N R
 - d. The medication is impossible to take, forgotten, or chosen not to take it Y N R

If YES to any of Question 29, score 1.

30. Has your family's homelessness been caused by any recent or past trauma or abuse? Y N R

If YES to Question 30, score 1.

31. Are there any children that have been removed from the family by a child protection service in the last six months? Y N R

32. Do you have any family legal issues like child custody, protection issues, divorce, or anything like that being resolved in court or needing to be resolved in court that would impact your housing or who may live within your housing? Y N R

If YES to Question 31 and/or Question 32, score 1.



33. At any point in the last six months, have any of your children been separated from you to live with another family member or friend? Y N R
34. In the last six months, have any of the children experienced abuse or trauma? Y N R
35. **If there are school-aged children:** Do your children attend school more often than not each week? Y N R

Score 1 if any of the following conditions are met:

- YES to Question 33;
- YES to Question 34;
- NO to Question 35.

36. In the last six months, have the adults in the family changed because of a new relationship, a separation, incarceration, military deployment, or anything like that? Y N R
37. Do you anticipate any other adults or children coming to live with your family in the first six months after you and your family get housed? Y N R

If YES to Question 36 and/or Question 37, score 1.

38. Does your family have a support network for when you need help with your children or other things that come up? Y N R
39. **If there are children 12 and younger as well as 13 and over:** In your household, do the older kids spend two or more hours on a typical day helping their younger siblings with things like getting ready for school, homework, dinner, bathing them, or anything like that? Y N R

If NO to Question 38 and/or YES to Question 39, score 1.

TOTAL SCORE



SCORING RANGE	RECOMMENDED COURSE OF ACTION
0-3	Assess for least intensive service supports
4-8	Assess for moderate and often time-limited supports
9+	Assess for high intensity supports lasting for a longer duration of time and perhaps even permanently

CONTACT INFORMATION

On a typical day, what is the best way to reach you?

Client Phone Number: _____

Client Email: _____

If that is unsuccessful, what is the next best way to reach you?

Staff Name: _____

Agency: _____



PHAC CES Assessment Point All in One Form

(For Head of Household Only)

Instructions – form should be completed on the same date as the VI-SPDAT.

Completion of this form will result in the individual or household being placed on the prioritization list.

Assessment Type:

Phone

Virtual

In person

SOCIAL SECURITY NUMBER

			-					-				
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<input type="checkbox"/>	Full SSN reported	<input type="checkbox"/>	Approximate or partial SSN reported
<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused

RACE (Check all that apply)

<input type="checkbox"/>	American Indian, Alaska Native, or Indigenous	<input type="checkbox"/>	White
<input type="checkbox"/>	Asian or Asian American	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Black, African American, or African	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Native Hawaiian or Pacific Islander		

ETHNICITY

<input type="checkbox"/>	Non-Hispanic / Non-Latin(a) (o) (x)	<input type="checkbox"/>	Client Refused
<input type="checkbox"/>	Hispanic / Latin(a) (o) (x)	<input type="checkbox"/>	Client Doesn't Know

GENDER (Check all that apply)

<input type="checkbox"/>	Female	<input type="checkbox"/>	Questioning
<input type="checkbox"/>	Male	<input type="checkbox"/>	Client Doesn't Know
<input type="checkbox"/>	Transgender	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	A gender that is not singularly 'Female' or 'Male'		

PRIOR LIVING SITUATION

<input type="checkbox"/>	Place not meant for habitation	<input type="checkbox"/>	Owned by client, with ongoing housing subsidy
<input type="checkbox"/>	Emergency shelter, including hotel or motel paid for with emergency shelter voucher	<input type="checkbox"/>	Permanent housing (other than RRH) for formerly homeless persons
<input type="checkbox"/>	Safe Haven	<input type="checkbox"/>	Rental by client, with no housing subsidy
<input type="checkbox"/>	Foster care home or foster care group home	<input type="checkbox"/>	Rental by client, housing subsidy <input type="checkbox"/> GPD TIP <input type="checkbox"/> VASH <input type="checkbox"/> RRH <input type="checkbox"/> HCV Voucher <input type="checkbox"/> Other
<input type="checkbox"/>	Hospital or other residential non-psychiatric medical facility	<input type="checkbox"/>	Residential project or halfway house with no homeless criteria
<input type="checkbox"/>	Jail, prison, or juvenile detention facility	<input type="checkbox"/>	Staying or living in a family member's room, apartment, or house <input type="checkbox"/> Permanently <input type="checkbox"/> Temporarily
<input type="checkbox"/>	Long-term care facility or nursing home	<input type="checkbox"/>	Staying or living in a friend's room, apartment, or house <input type="checkbox"/> Permanently <input type="checkbox"/> Temporarily
<input type="checkbox"/>	Psychiatric hospital or other psychiatric facility	<input type="checkbox"/>	Transitional housing for homeless persons (including homeless youth)
<input type="checkbox"/>	Substance abuse treatment facility or detox center	<input type="checkbox"/>	Host Home (non-crisis)
<input type="checkbox"/>	Hotel or motel paid for without emergency shelter voucher	<input type="checkbox"/>	Rental by client in a public housing unit
<input type="checkbox"/>	Owned by client, no ongoing housing subsidy	<input type="checkbox"/>	Owned by client, with ongoing housing subsidy

LENGTH OF STAY IN PRIOR LIVING SITUATION

<input type="checkbox"/>	One night or less	<input type="checkbox"/>	90 days or more, but less than one year
<input type="checkbox"/>	Two to six nights	<input type="checkbox"/>	One year or longer
<input type="checkbox"/>	One week or more, but less than one month	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	One month or more, but less than 90 days	<input type="checkbox"/>	Client refused

ON THE NIGHT BEFORE WAS CLIENT ON THE STREETS/ES/SH?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
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APPROXIMATE DATE HOMELESSNESS STARTED

		/			/				
Month			Day			Year			

NUMBER OF TIMES THE CLIENT HAS BEEN HOMELESS IN THE PAST THREE YEARS

<input type="checkbox"/> One time (this time)	<input type="checkbox"/> Four or more times
<input type="checkbox"/> Two times	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Three times	<input type="checkbox"/> Client refused

TOTAL NUMBER OF MONTHS THE CLIENT HAS BEEN HOMELESS IN THE PAST THREE YEARS

<input type="checkbox"/> One month or less	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Between 2 and 12 months Enter number of months (_____)	<input type="checkbox"/> Client refused
<input type="checkbox"/> More than 12 months	

Current Living Situation (Where the client slept last night)

<input type="checkbox"/> Place not meant for habitation	<input type="checkbox"/> Rental by client, with GPD TIP subsidy
<input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher	<input type="checkbox"/> Rental by client, with VASH housing subsidy
<input type="checkbox"/> Safe Haven	<input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons
<input type="checkbox"/> Foster care home or foster care group home	<input type="checkbox"/> Rental by client, with RRH or equivalent subsidy
<input type="checkbox"/> Hospital or other residential non-psychiatric medical facility	<input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based)
<input type="checkbox"/> Jail, prison, or juvenile detention facility	<input type="checkbox"/> Rental by client in a public housing unit
<input type="checkbox"/> Long-term care facility or nursing home	<input type="checkbox"/> Rental by client, no ongoing housing subsidy
<input type="checkbox"/> Psychiatric hospital or other psychiatric facility	<input type="checkbox"/> Rental by client, with other ongoing housing subsidy
<input type="checkbox"/> Substance abuse treatment facility or detox center	<input type="checkbox"/> Owned by client, with ongoing housing subsidy
<input type="checkbox"/> Residential project or halfway house with no homeless criteria	<input type="checkbox"/> Owned by client, no ongoing housing subsidy
<input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher	<input type="checkbox"/> Other: Specify _____
<input type="checkbox"/> Transitional housing for homeless persons (including homeless youth)	<input type="checkbox"/> Worker Unable to Determine
<input type="checkbox"/> Host Home (non-crisis)	<input type="checkbox"/> Data Not Collected
<input type="checkbox"/> Staying or Living in a friend's room, apartment, or house	<input type="checkbox"/> Client Refused
<input type="checkbox"/> Staying or living in a family member's room apartment, or house	<input type="checkbox"/> Client Doesn't Know

Number of Adults: _____

Do any of the adults identify as male?

Yes No

Number of children under 18? _____

Are any of the children under the age of 1?

Yes No

Do you identify as LGBT?

Yes Client Doesn't Know Data Not Collected
 No Client refused Not Applicable

Do any members of your household identify as LGBT?

Yes Client Doesn't Know Data Not Collected
 No Client refused Not Applicable

Is there any adult in the household in their third trimester of pregnancy?

Yes No Not Applicable

Do you have any household income?

Yes Client Doesn't Know Data Not Collected
 No Client refused Not Applicable

Gross Income Per Month: \$ _____

Do you consider yourself a survivor of interpersonal violence?

Yes Client Doesn't Know Data Not Collected
 No Client refused Not Applicable

Coordinated Entry Event

– Problem Solving/Diversion/Rapid Resolution intervention or service

Problem Solving/Diversion/Rapid Resolution intervention or service result – client housed/re-housed in a safe alternative?

Yes No

If applicable, please complete an additional UDE form for each household member.

PROJECT NAME _____

PROJECT START DATE

		/			/			
Month			Day			Year		

CLIENT LOCATION VA-501 VA-503 VA-505 VA-507 VA-508

First Name		Middle		Last		Suffix	
<input type="checkbox"/>	Full Name Reported	<input type="checkbox"/>	Partial or Street Name	<input type="checkbox"/>	Client Doesn't Know	<input type="checkbox"/>	Client Refused

SOCIAL SECURITY NUMBER

			-								
--	--	--	---	--	--	--	--	--	--	--	--

<input type="checkbox"/>	Full SSN reported	<input type="checkbox"/>	Approximate or partial SSN reported
<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused

DATE OF BIRTH

		/			/			
Month			Day			Year		

<input type="checkbox"/>	Full SSN reported	<input type="checkbox"/>	Approximate or partial SSN reported
<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused

RACE (Check all that apply)

<input type="checkbox"/>	American Indian, Alaska Native, or Indigenous	<input type="checkbox"/>	White
<input type="checkbox"/>	Asian or Asian American	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Black, African American, or African	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Native Hawaiian or Pacific Islander		

ETHNICITY

<input type="checkbox"/>	Non-Hispanic/Latin(a)(o)(x)	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Hispanic/Latin(a)(o)(x)	<input type="checkbox"/>	Client refused

GENDER (Check all that apply)

<input type="checkbox"/>	Female	<input type="checkbox"/>	A gender that is not singularly 'Female' or 'Male'
<input type="checkbox"/>	Male	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Transgender	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Questioning		

VETERAN STATUS

<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused

DISABLING CONDITION

Client has a Developmental Disability, HIV/AIDs, and/or another condition that is expected to be of long, indefinite duration and substantially limits their ability to live independently?

<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused

RELATIONSHIP TO HEAD OF HOUSEHOLD

<input type="checkbox"/>	Self (head of household)	<input type="checkbox"/>	Head of household's other relation member (other relation to head of household)
<input type="checkbox"/>	Head of household's child	<input type="checkbox"/>	Other: non-relation member
<input type="checkbox"/>	Head of household's spouse or partner	HoH Name: _____	

PRIOR LIVING SITUATION

<input type="checkbox"/>	Place not meant for habitation	<input type="checkbox"/>	Owned by client, with ongoing housing subsidy
<input type="checkbox"/>	Emergency shelter, including hotel or motel paid for with emergency shelter voucher	<input type="checkbox"/>	Permanent housing (other than RRH) for formerly homeless persons
<input type="checkbox"/>	Safe Haven	<input type="checkbox"/>	Rental by client, with NO housing subsidy
<input type="checkbox"/>	Foster care home or foster care group home	<input type="checkbox"/>	Rental by client, WITH housing subsidy: <input type="checkbox"/> GPD TIP <input type="checkbox"/> VASH <input type="checkbox"/> RRH <input type="checkbox"/> HCV Voucher <input type="checkbox"/> Other (including RRH)
<input type="checkbox"/>	Hospital or other residential non-psychiatric medical facility	<input type="checkbox"/>	Residential project or halfway house with no homeless criteria
<input type="checkbox"/>	Jail, prison, or juvenile detention facility	<input type="checkbox"/>	Staying or living in a family member's room, apartment, or house: <input type="checkbox"/> Permanently <input type="checkbox"/> Temporarily
<input type="checkbox"/>	Long-term care facility or nursing home	<input type="checkbox"/>	Staying or living in a friend's room, apartment, or house: <input type="checkbox"/> Permanently <input type="checkbox"/> Temporarily
<input type="checkbox"/>	Psychiatric hospital or other psychiatric facility	<input type="checkbox"/>	Transitional housing for homeless persons (including homeless youth)
<input type="checkbox"/>	Substance abuse treatment facility or detox center	<input type="checkbox"/>	Host Home (non-crisis)
<input type="checkbox"/>	Hotel or motel paid for without emergency shelter voucher	<input type="checkbox"/>	Rental by client in a public housing unit
<input type="checkbox"/>	Owned by client, no ongoing housing subsidy		

LENGTH OF STAY IN PRIOR LIVING SITUATION

<input type="checkbox"/>	One night or less	<input type="checkbox"/>	90 days or more, but less than one year
<input type="checkbox"/>	Two to six nights	<input type="checkbox"/>	One year or longer
<input type="checkbox"/>	One week or more, but less than one month	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	One month or more, but less than 90 days	<input type="checkbox"/>	Client refused

ON THE NIGHT BEFORE WAS CLIENT ON THE STREETS/ES/SH?

Yes No

APPROXIMATE DATE HOMELESSNESS STARTED:

		/			/			
Month			Day			Year		

NUMBER OF TIMES THE CLIENT HAS BEEN HOMELESS IN THE PAST THREE YEARS

<input type="checkbox"/>	One time (this time)	<input type="checkbox"/>	Four or more times
<input type="checkbox"/>	Two times	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Three times	<input type="checkbox"/>	Client refused

TOTAL NUMBER OF MONTHS THE CLIENT HAS BEEN HOMELESS IN THE PAST THREE YEARS

<input type="checkbox"/>	One month or less	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Between 2 and 12 months: Enter number of months (_____)	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	More than 12 months		

HOUSING MOVE IN DATE (PH only)

		/			/			
Month			Day			Year		

I certify that my answers are true and complete to the best of my knowledge and understand that false or misleading information may result in delay of assistance.

CLIENT SIGNATURE

INTAKE DATE



PORTSMOUTH COORDINATED ASSESSMENT NETWORK

Prioritization Guide

(TO BE PRESENTED WITH PCAN REQUEST)

HMIS # _____ HOH INITIAL _____ PCAN Date: _____

- | | | | |
|--|------|-----|-------|
| 1. Documented Disability | | (2) | _____ |
| 2. L.O.T. Homeless: 12 mo. continuous or 4 x in 3 yrs. | | (2) | _____ |
| 3. L.O.T. Homeless: < 12 Mo. | | (1) | _____ |
| 4. Serious Medical Condition | | (1) | _____ |
| 5. Pregnant | | (1) | _____ |
| 6. Unsheltered (NMFH) | | (2) | _____ |
| 7. ES/H-M Pd. w/voucher | | (2) | _____ |
| 8. Inst./Hosp./ Non-Psych/Jail | < 90 | (1) | _____ |
| 9. Inst./Hosp./ Non-Psych/Jail | > 90 | (1) | _____ |
| 10. Psych Hosp./SA | | (1) | _____ |
| 11. RSO Status | | (1) | _____ |
| 12. H.O.H. Veteran | | (2) | _____ |
| 13. Youth (18-24) | | (2) | _____ |
| 14. +62 Years Old | | (2) | _____ |
| 15. 55-61 Years Old | | (1) | _____ |
| 16. D/V Survivor (w/in 30 days) | | (1) | _____ |
| 17. Zero Income | | (1) | _____ |
| 18. VI-SPDAT Score (<8) | | (1) | _____ |
| 19. VI-SPDAT Score (8-12) | | (2) | _____ |
| 20. VI-SPDAT Score (13-17) | | (3) | _____ |
| 21. 2 nd VI-SPDAT (w/in 90 days) | | (1) | _____ |

TOTAL SCORE (Sum of all above) _____

PRESENTED BY: _____

AGENCY _____

Hampton Roads HMIS
Client Consent Form
Authorization for Release of Information

Agency Name _____ Program Name _____

Client Name _____

Dependent children, if any (first and last names and date of birth)

I know that this agency is part of the Hampton Roads HMIS (Homeless Management Information System.) The HMIS is a system that uses computers to collect information about homelessness in order to help pay for services to people who are homeless.

With this written consent, HMIS Participating Agencies may share, see and update basic information about me and my children including name, social security number, gender, and birth date. No restricted information about my health, medical needs, mental health or domestic violence can be shared unless I sign a separate agreement. A current list of HMIS Participating Agencies is available on The Planning Council website at www.theplanningcouncil.org.

Other agency staff members who have signed the HMIS confidentiality agreement will be allowed to see, enter or use information kept in the HMIS. This agency will never give information about a person to anyone outside this system without the person's written consent, or as required by law through a court order.

Information in this system may not be used to deny outreach, shelter or housing. My decision to sign or not sign this consent document will not be used to deny outreach, shelter or housing services. I may revoke my consent at any time, in writing, and no **new** information will be shared. This consent will end three years from today.

I have a right to see my HMIS record, ask for changes, and to have a copy of my record from this agency upon written request.

I authorize this agency to share my basic information with other agencies on the Hampton Roads HMIS.

I do not authorize this agency to share my basic information with other agencies on the Hampton Roads HMIS.

Client Signature

Date

Agency Witness

Date

Portsmouth Homeless Action Consortium (PHAC)
CONSENT TO EXCHANGE INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to work together effectively to provide or coordinate these services or benefits.

I, _____, am signing this form on behalf of _____

(CLIENT'S ADDRESS)

(CLIENT'S DATE OF BIRTH)

(CLIENT'S SSN)

My relationship to the client is: [] Self [] Parent [] Power of Attorney [] Guardian [] Other Legally Authorized Representative
Please see reverse side for additional parties included in this Consent to Exchange Information.

I want the following confidential information to be exchanged:

Table with 3 columns: Yes/No, Yes/No, Yes/No. Rows include Assessment Information, Financial Information, Benefits/Services Needed, Planned, and/or Received, Drug / Alcohol Abuse, Medical Diagnosis, Mental Health Diagnosis, Medical Records, Psychological Records, HIV, Educational Records, Psychiatric Records, Criminal Justice Records, Employment Records.

Other Information (write in):
I want: _____

(NAME AND ADDRESS OF REFERRING AGENCY AND STAFF CONTACT PERSON)

And the following other agencies to be able to exchange this information:

Table listing agencies: Housing Crisis Hotline, Portsmouth Coordinated Entry, Portsmouth Resources Area Coalition (PARC), Portsmouth Volunteers for the-Homeless (PVH), Help and Emergency Response Shelter (HER), Eggleston, STOP Inc., Virginia Supportive Housing, Oasis Social Ministry, Portsmouth Behavioral Healthcare - Services, Portsmouth Department of Health, Portsmouth Public Schools, Portsmouth Department of Social Services, Portsmouth Redevelopment and Housing Authority (PRHA), Portsmouth Christian Outreach Ministries (PCOM), Other, Legal Aid Society of Eastern Virginia, Maryview Foundation, Life Changers, Disabled American Veterans (DAV), Department of Veteran Affairs (VA), Virginia Beach Community- Development Corporation -(VBCDC), Hampton Roads Community Health, Other.

I want this information to be exchanged ONLY for the following purpose(s):

- [] Service Coordination
[] Eligibility Determination
Continued Medical/Mental Health Treatment
Other (write in): _____

I understand that this information may be shared as written information and/or fax, in meetings or by telephone, and as computerized data/HMIS entry. I understand this release is in alignment with current HMIS policies and will be effective for a period of one (1) year from the date of execution if verbal and three (3) years if signed.

I understand that my records are protected by state and federal confidentiality laws and cannot be disclosed without my written consent. I authorize the release of personal health information regarding my treatment to the aforementioned agencies. This authorization includes information related to alcohol and drug abuse, mental health treatment, except

psychotherapy notes, and confidential HIV related information. HIV, alcohol or drug information will not be disclosed without my written consent. I understand that I may revoke this authorization at any time, except to the extent that those receiving this authorization have already acted in reliance upon it. Signing this release is voluntary. My treatment or access to services will not be conditioned on my authorization of disclosure. I have the right to know what information about me has been shared, and why, when and with whom it was shared. If I ask, each agency will show me this information.

I want all the agencies to accept a copy of this form as a valid consent to share information.

If I do not sign this form, information will not be shared and I will have to contact each agency individually to give them information about me that they need. (please sign below)

Signature(s) _____ Date _____
(Consenting Person(s))

Person Explaining Form: _____
(Name) (Title) (Phone Number)

Verbal Consent Confirmation: Date _____ Time _____

Verbal Consent Provided? Circle One: Yes No

Additional Parties Named in the Release of Information

Name: _____ **Relationship:** _____
DOB: _____ **Last 4 SS #:** _____

Name: _____ **Relationship:** _____
DOB: _____ **Last 4 SS #:** _____

Name: _____ **Relationship:** _____
DOB: _____ **Last 4 SS #:** _____

Name: _____ **Relationship:** _____
DOB: _____ **Last 4 SS #:** _____

Client Signature: _____ Date: _____

Agency Witness: _____ Date: _____

FOR AGENCY USE ONLY

CONSENT HAS BEEN:

- Revoked in entirety
- Partially revoked as follows: _____

NOTIFICATION THAT CONSENT WAS REVOKED WAS BY:

- Letter (Attached Copy) Telephone In Person

DATE REQUEST RECEIVED:

AGENCY REPRESENTATIVE RECEIVING REQUEST:

(Agency Representative's Full Name and Title)

(Agency Address and Telephone Number)