

ADMINISTRATION

First Name:	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

OPENING SPEAKING POINTS

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

- The purpose of doing the triage for youth aged 24 years of age or younger
- 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, **without penalty**
- 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

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.



SECTION ONE: PRESENTING NEEDS

1. Most days can you:

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

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

SECTION TWO: HOUSING HISTORY

2. How long has it been since you lived in stable, permanent housing? _____

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

4. IF THE ANSWER TO QUESTION 3 IS 4 OR MORE:

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

5. Do you have any diagnosed, documented, disabling conditions? Y N R

Score 1 if YES to Question 5 and any of the following conditions are met:

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

6. Have you ever lived in a home that you own or an apartment in your name? Y N R

7. Have you and/or your family spent a lot of time without stable housing?
Did you all move around a lot? Y N R

8. Were you in an out-of-home placement (foster care, group home, etc.) as a minor? Y N R

Score 1 if any of the following conditions are met:

- NO to Question 6;
- YES to Question 7;
- YES to Question 8.



SECTION THREE: VULNERABILITIES AND HOUSING SUPPORT NEEDS

- | 9. In the last 6 months, how many times have you: | <i># of times</i> |
|--|-------------------|
| a. Gone to the emergency room/department | _____ |
| b. Taken an ambulance | _____ |
| c. Been hospitalized as an inpatient | _____ |
| d. Used a crisis service or hotline like suicide prevention, mental health crisis or teen/youth crisis counsellor at school or a drop-in | _____ |
| 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, juvenile detention or prison | _____ |

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

10. Since you have been homeless:
- | | | | |
|--|----------------------------|----------------------------|----------------------------|
| a. Have you been beaten up or assaulted | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> R |
| b. Have you threatened to beat up or assault someone else | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> R |
| c. Have you threatened to harm yourself or harmed yourself | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> R |
| d. Has anyone threatened you with violence or made you feel unsafe | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> R |
| e. Has anyone tried to control you through violence or threats of violence whether that be a stranger, friend, partner, relative or parent | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> R |

If YES to any of Question 10, score 1.

11. Do you have any legal stuff going on right now that may result in any of the following:
- | | | | |
|---|----------------------------|----------------------------|----------------------------|
| a. Being locked up | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> R |
| b. Having to pay fines or fees that you cannot afford | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> R |
| c. Impact your ability to get housing | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> R |
| d. Impact where you could live in your housing | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> R |
12. Have you ever been convicted of a crime that makes it difficult to access or maintain housing? Y N R
13. Did you spend time in Juvenile Corrections & Detention prior to age 18? Y N R

Score 1 if any of the following conditions are met:

- YES to Question 11 a, b, c or d;
- YES to Question 12;
- YES to Question 13.



14. Does anyone trick, manipulate, exploit or force you to do things you do not want to do? Y N R

15. Where do you sleep most frequently? (*select one response*)

- Shelters Transitional Housing Safe Haven Couch Surfing/Hopping*
 Outdoors Car Other _____

16. Do you ever do things that may be considered risky or harmful like run drugs, share a needle, do sex work or survival sex, or anything like that? Y N R

Score 1 if any of the following conditions are met:

- YES to Question 14;
- If the person stays any place other than Shelters or Transitional Housing or Safe Haven in Question 15;
- YES to Question 16.

17. Is there anybody that thinks you owe 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

18. Do you get any money from the government, a job, working under the table, day labour, an inheritance or a pension, or anything like that? Y N R

19. Do you ever gamble with money you 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 17;
- NO to Question 18;
- YES to Question 19.

20. Do you have planned activities, other than activities for survival, at least four days per week that make you feel happy and fulfilled? Y N R

If NO to Question 20, score 1.

21. Do you have a collection of belongings that gets in the way with your ability to access services or housing? Y N R NA

If YES to Question 21, score 1.

22. Would you say that your current homelessness was caused by any of the following:

- a. You went on the run from a family home, group home, or foster home Y N R
- b. There was violence at the home between family members Y N R
- c. There were differences in religious beliefs between your parents/guardian/caregivers Y N R
- d. There were conflicts about gender identity or sexual orientation Y N R

*Couch surfing/hopping does not meet HUD homeless eligibility however there are other programs for which a youth experiencing homelessness and couch hopping may qualify, i.e. programs funded by RHY/FSBY, and other State or local programs such as basic center program or extended foster care benefits. Communities should take this into consideration when verifying eligibility for youth experiencing homelessness.



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

If YES to any of Question 22, and/or NO to Question 23, score 1.

24. Are you 17 years of age or younger? Y N R

25. Do you have any physical or mental health issues or cognitive issues including a brain injury, that you might require assistance to access or keep housing? Y N R

26. Are you currently pregnant (if applicable)? Y N R

27. Were you pregnant or did you get someone else pregnant as a minor? Y N R

If YES to Question 24, Question 25, Question 26 and/or Question 27, score 1.

28. Do you use alcohol or drugs in a way that it:

a. Impacts your 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

29. Did you try marijuana at or under the age of 12 years old? Y N R

If YES to any of Question 28 and/or Question 29, score 1.

30. Are there any medications that, for whatever reason:

a. You sell instead of taking Y N R

b. You use in a way other than how it is prescribed Y N R

c. You can't get to because you don't feel safe Y N R

d. You find impossible to take or you forget to take Y N R

If YES to any of Question 30, score 1.

31. Has your homelessness been caused by any recent or past trauma or abuse? Y N R

If YES to Question 31, score 1.



32. High Risk of Long Term Homelessness

Score 1 if all of the following conditions are met:

- YES to Question 13
- YES to Question 22 (a, b c or d);
- YES to Question 27;
- YES to Question 29.

TOTAL SCORE

SCORING RANGE	RECOMMENDED COURSE OF ACTION
0-3	Assess for least intensive service supports
4-7	Assess for moderate and often time-limited supports
8+	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?

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



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:

Yes/No	Yes/No	Yes/No
<input type="checkbox"/> <input type="checkbox"/> Assessment Information	<input type="checkbox"/> <input type="checkbox"/> Medical Diagnosis	<input type="checkbox"/> <input type="checkbox"/> Educational Records
<input type="checkbox"/> <input type="checkbox"/> Financial Information	<input type="checkbox"/> <input type="checkbox"/> Mental Health Diagnosis	<input type="checkbox"/> <input type="checkbox"/> Psychiatric Records
<input type="checkbox"/> <input type="checkbox"/> Benefits/Services Needed, Planned, and/or Received	<input type="checkbox"/> <input type="checkbox"/> Medical Records	<input type="checkbox"/> <input type="checkbox"/> Criminal Justice Records
<input type="checkbox"/> <input type="checkbox"/> Drug / Alcohol Abuse	<input type="checkbox"/> <input type="checkbox"/> Psychological Records	<input type="checkbox"/> <input type="checkbox"/> Employment Records
	<input type="checkbox"/> <input type="checkbox"/> HIV	

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:

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

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)