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

			-				-				

☐	Full SSN reported	☐	Approximate or partial SSN reported
☐	Client doesn't know	☐	Client refused

RACE (Check all that apply)

☐	American Indian, Alaska Native, or Indigenous	☐	White
☐	Asian or Asian American	☐	Client doesn't know
☐	Black, African American, or African	☐	Client refused
☐	Native Hawaiian or Pacific Islander		

ETHNICITY

☐	Non-Hispanic / Non-Latin(a) (o) (x)	☐	Client Refused
☐	Hispanic / Latin(a) (o) (x)	☐	Client Doesn't Know

GENDER (Check all that apply)

☐	Female	☐	Questioning
☐	Male	☐	Client Doesn't Know
☐	Transgender	☐	Client refused
☐	A gender that is not singularly 'Female' or 'Male'		

PRIOR LIVING SITUATION

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

LENGTH OF STAY IN PRIOR LIVING SITUATION

☐	One night or less	☐	90 days or more, but less than one year
☐	Two to six nights	☐	One year or longer
☐	One week or more, but less than one month	☐	Client doesn't know
☐	One month or more, but less than 90 days	☐	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

☐	One time (this time)	☐	Four or more times
☐	Two times	☐	Client doesn't know
☐	Three times	☐	Client refused

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

☐	One month or less	☐	Client doesn't know
☐	Between 2 and 12 months **Enter number of months (_____)**	☐	Client refused
☐	More than 12 months		

Current Living Situation (Where the client slept last night)

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

Answer Questions below if client is in an Institutional or Temporary or Permanent Housing Situation (any tinted row above):

- **Is client going to have to leave their current living situation withing 14 days?**

☐ Yes	☐ Client Doesn't Know	☐ Data Not Collected
☐ No	☐ Client Refused	☐ Not Applicable

- **<u>If 'Yes" to 'Is client going to have to leave their current living situation withing 14 days?' answer the following questions.</u>**

1. Has a subsequent residence been identified?

☐ Yes	☐ Client Doesn't Know	☐ Data Not Collected
☐ No	☐ Client Refused	☐ Not Applicable

2. **Does the individual or family have resources or support networks to obtain other permanent housing?**

☐ Yes	☐ Client Doesn't Know	☐ Data Not Collected
☐ No	☐ Client Refused	☐ Not Applicable

3. **Has the client had a lease or ownership interest in a permanent housing unit in the last 60 days?**

☐ Yes	☐ Client Doesn't Know	☐ Data Not Collected
☐ No	☐ Client Refused	☐ Not Applicable

4. **Has the client moved two (2) or more time in the last 60 days?**

☐ Yes	☐ Client Doesn't Know	☐ Data Not Collected
☐ No	☐ Client Refused	☐ Not Applicable

5. **Location details:** _____

Crisis Needs Assessment

In what locality do you reside or have established yourself as a resident? _____

Are you temporarily displaced elsewhere?

☐ Yes ☐ No

- **If yes, in what city/county?** _____

- **If yes, do you intend to remain there?**

☐ Yes ☐ No ☐ Not Applicable

If the household is staying in a place not meant for habitation, select the specific type of location:

☐ Abandoned Building	☐ Garage/Shed/Porch	☐ Vehicle
☐ Beach	☐ Park	☐ Woods
☐ Bus Station	☐ Street/Sidewalk	☐ Not Applicable

Does anyone in your household have a severe medical condition?

☐ Yes ☐ No

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.

Universal Data Elements Intake

Staff Initials _____

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	
☐	Full Name Reported	☐	Partial or Street Name	☐	Client Doesn't Know	☐	Client Refused

SOCIAL SECURITY NUMBER ___-___-____

☐	Full SSN reported	☐	Approximate or partial SSN reported
☐	Client doesn't know	☐	Client refused

DATE OF BIRTH / / (Month / Day / Year)

☐	Full SSN reported	☐	Approximate or partial SSN reported
☐	Client doesn't know	☐	Client refused

RACE (Check all that apply)

☐	American Indian, Alaska Native, or Indigenous	☐	White
☐	Asian or Asian American	☐	Client doesn't know
☐	Black, African American, or African	☐	Client refused
☐	Native Hawaiian or Pacific Islander		

ETHNICITY

☐	Non-Hispanic/Latin(a)(o)(x)	☐	Client doesn't know
☐	Hispanic/Latin(a)(o)(x)	☐	Client refused

GENDER (Check all that apply)

☐	Female	☐	A gender that is not singularly 'Female' or 'Male'
☐	Male	☐	Client doesn't know
☐	Transgender	☐	Client refused
☐	Questioning		

VETERAN STATUS

☐	No	☐	Client doesn't know
☐	Yes	☐	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?*

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused

RELATIONSHIP TO HEAD OF HOUSEHOLD

☐	Self (head of household)	☐	Head of household's other relation member (other relation to head of household)
☐	Head of household's child	☐	Other: non-relation member
☐	Head of household's spouse or partner	**HoH Name:** _____	

Universal Data Elements Intake Staff Initials _____

PRIOR LIVING SITUATION

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

LENGTH OF STAY IN PRIOR LIVING SITUATION

☐	One night or less	☐	90 days or more, but less than one year
☐	Two to six nights	☐	One year or longer
☐	One week or more, but less than one month	☐	Client doesn't know
☐	One month or more, but less than 90 days	☐	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

☐	One time (this time)	☐	Four or more times
☐	Two times	☐	Client doesn't know
☐	Three times	☐	Client refused

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

☐	One month or less	☐	Client doesn't know
☐	Between 2 and 12 months: **Enter number of months (_____)**	☐	Client refused
☐	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.	2nd 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

Rev. 10-31-18

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
□ □ Assessment Information	□ □ Medical Diagnosis	□ □ Educational Records
□ □ Financial Information	□ □ Mental Health Diagnosis	□ □ Psychiatric Records
□ □ Benefits/Services Needed, Planned, and/or Received	□ □ Medical Records	□ □ Criminal Justice Records
	□ □ Psychological Records	□ □ Employment Records
□ □ Drug / Alcohol Abuse	□ □ 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 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 will be effective for a period of one (1) year from the date of execution.

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)