



**Suggested Script for beginning the interview for completing the VI-SPDAT**

Hi,

My name is \_\_\_\_\_ and I am with \_\_\_\_\_.

I am going to be asking you some questions in order to determine how we are best able to assist you. It normally takes about 7 minutes to complete. The questions really only need a yes or no answer. I know it might be hard to answer some questions with a yes or no, but please do your best. You are able to skip or refuse to answer any question that I ask, but also understand that if you do, we might be limited in the assistance we can give you.

All of this information is confidential and treated as such. I have a release form for you to sign that will allow me to discuss your information with other people who can help me assist you.

If you do not understand a question, please let me know and I will do my best to explain it to you.

Finally, I need you to answer the question honestly. There is no right or wrong answer—and there really is no answer that we are looking for here. We are just trying to get to know you and the best way we are able to help you.

## Administration

<b>Interviewer's Name</b>	<b>Agency</b>	<input type="checkbox"/> Team <input type="checkbox"/> Staff <input type="checkbox"/> Volunteer
<b>Survey Date</b>	<b>Survey Time</b>	<b>Survey Location</b>
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

<b>First Name</b>	<b>Nickname</b>	<b>Last Name</b>	
_____	_____	_____	
<b>In what language do you feel best able to express yourself?</b> _____			
<b>Date of Birth</b>	<b>Age</b>	<b>Social Security Number</b>	<b>Consent to participate</b>
DD/MM/YYYY	____/____/_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

**SCORE:**

## 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:**

2. How long has it been since you lived in permanent stable housing? \_\_\_\_\_  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:**

## 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:**

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:**

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:**

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:**

## 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:**

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:**

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:**

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:**

## 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:**

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:**

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:**

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

**SCORE:**

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:**

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:**

## Scoring Summary

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

## Follow-Up Questions

<b>On a regular day, where is it easiest to find you and what time of day is easiest to do so?</b>	place: _____
	time: ____ : ____ or
<b>Is there a phone number and/or email where someone can safely get in touch with you or leave you a message?</b>	phone: (____) _____ - _____ email: _____
<b>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?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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

# **SCC-S RAPID RE-HOUSING PRIORITIZATION TOOL**

## **SCORING SHEET**

Client Name: \_\_\_\_\_ SCC Date: \_\_\_\_\_

### **Vulnerability Scoring Matrix**

1. Documented Disability (2) \_\_\_\_\_
2. Unsheltered (2) \_\_\_\_\_
3. Youth (18-24) (1) \_\_\_\_\_
4. Elderly (60+) (1) \_\_\_\_\_
5. HIV+ (1) \_\_\_\_\_
6. VI-SPDAT Score (8-12 =1) \_\_\_\_\_
7. VI-SPDAT Score (13-17=2) \_\_\_\_\_
8. RSO Status (1) \_\_\_\_\_
9. Serious Medical Condition (1) \_\_\_\_\_
10. Pregnant (1) \_\_\_\_\_
11. D/V Survivor (w/in 30 days) (1) \_\_\_\_\_
12. Zero Income (1) \_\_\_\_\_
13. L.O.T. Homeless: 5 years+ Continuous (2) \_\_\_\_\_
14. Incarceration Hx: 10 years+ Combined (1) \_\_\_\_\_
15. L.O.T. Bookmarked: 3<sup>rd</sup> SCC (1) \_\_\_\_\_
16. L.O.T. Bookmarked: 3 Months+ (2) \_\_\_\_\_

**TOTAL SCORE: (Sum of all above)** \_\_\_\_\_

# SVHC 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

<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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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'		

### 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

**PRIOR LIVING SITUATION (where the client slept last night)**

<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 (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	<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**

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>
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 <b>Enter number of months (_____)</b>	<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 is a family member's room apartment, or house	<input type="checkbox"/>	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 within 14 days?

<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Data Not Collected
<input type="checkbox"/> No	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Not Applicable

- If 'Yes' to 'Is client going to have to leave their current living situation within 14 days?' answer the following questions.

1. Has a subsequent residence been identified?

<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Data Not Collected
<input type="checkbox"/> No	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Not Applicable

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

<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Data Not Collected
<input type="checkbox"/> No	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Not Applicable

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

- |                              |  |   |
|------------------------------|--|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Data Not Collected |
| <input type="checkbox"/> No  | <input type="checkbox"/> Client Refused      | <input type="checkbox"/> Not Applicable     |

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

- |                              |  |   |
|------------------------------|--|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Data Not Collected |
| <input type="checkbox"/> No  | <input type="checkbox"/> Client Refused      | <input type="checkbox"/> 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?**

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

• If yes, in what city/county? \_\_\_\_\_

• If yes, do you intend to remain there?

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

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

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Abandoned Building | <input type="checkbox"/> Garage/Shed/Porch | <input type="checkbox"/> Vehicle        |
| <input type="checkbox"/> Beach              | <input type="checkbox"/> Park              | <input type="checkbox"/> Woods          |
| <input type="checkbox"/> Bus Station        | <input type="checkbox"/> Street/Sidewalk   | <input type="checkbox"/> Not Applicable |

**Does anyone in your household have a severe medical condition?**

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

**Does anyone in your household have a severe mental health condition?**

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

**Number of Adults:** \_\_\_\_\_

**Do any of the adults identify as male?**

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

**Number of children under 18?** \_\_\_\_\_

**Are any of the children under the age of 1?**

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

**Do you identify as LGBT?**

- |                              |  |   |
|------------------------------|--|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Data Not Collected |
| <input type="checkbox"/> No  | <input type="checkbox"/> Client refused      | <input type="checkbox"/> Not Applicable     |

**Do any members of your household identify as LGBT?**

- |                              |  |   |
|------------------------------|--|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Data Not Collected |
| <input type="checkbox"/> No  | <input type="checkbox"/> Client refused      | <input type="checkbox"/> Not Applicable     |

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

- |                              |                             |   |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Applicable |
|------------------------------|-----------------------------|---|

**Do you have any household income?**

- |                              |  |   |
|------------------------------|--|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Data Not Collected |
| <input type="checkbox"/> No  | <input type="checkbox"/> Client refused      | <input type="checkbox"/> Not Applicable     |

**Gross Income Per Month:** \$ \_\_\_\_\_

**Do you consider yourself a survivor of interpersonal violence?**

- |                              |  |   |
|------------------------------|--|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Data Not Collected |
| <input type="checkbox"/> No  | <input type="checkbox"/> Client refused      | <input type="checkbox"/> Not Applicable     |

**Does the client/household meet the criteria for the Elder Status priority group?**

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

**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?**

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

**If applicable, please complete an additional UDE form for each household member using the form below.**

**Hampton Roads HMIS**  
**Client Consent Form**  
**Authorization for Release of Information**

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**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](http://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.

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Client Signature

Date

---

Agency Witness

Date

**SVHC Service Coordination Committee**  
**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 NAME)

---

(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"/> Psychological Records	<input type="checkbox"/> <input type="checkbox"/> Employment Records

Other Information (write in):

I want:

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

And all SVHC member agencies to be able to exchange this information. (A full list of member agencies can be found at [www.svhcva.org](http://www.svhcva.org))

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

- Service Coordination and Treatment Planning  Continued Medical/Mental Health Treatment  
 Eligibility Determination  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 three (3) years 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 res-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.***

Signature(s) \_\_\_\_\_ Date \_\_\_\_\_

(Client/Consenting Person Signature)

Person Explaining Form: \_\_\_\_\_  
(Name) \_\_\_\_\_ (Title) \_\_\_\_\_ (Phone Number) \_\_\_\_\_

## **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 #: \_\_\_\_\_

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: \_\_\_\_\_

Spouse Signature (*If Applicable*): \_\_\_\_\_ 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:**

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(*Agency Representative's Full Name and Title*)

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(*Agency Address and Telephone Number*)