



Smart Path Confidential Assessment

Single Adult

**CLIENT INFORMED CONSENT &
RELEASE OF INFORMATION AUTHORIZATION**

_____ is a Partner Agency in the Homeless Management Information System (HMIS). HMIS is a computerized system that can improve programs for homeless persons by allowing information to be shared among partner agencies that provide services such as shelter and health care and/or homelessness research or administrative services. The system is Internet-based and uses many security protections to ensure confidentiality. Partner agencies currently include:

- | | |
|--|--|
| Association of Faith Communities | City of Santa Cruz- River St Camp |
| Community Action Board of Santa Cruz | Downtown Streets Team |
| Department of Veterans Affairs | Employment and Benefit Services |
| Encompass | Homeless Garden Project |
| Encompass HOPWA - PRIVATE | Homeless Outreach Proactive Engagement (HOPES) |
| Families In Transition | Housing Choices |
| Front St | Janus of Santa Cruz |
| Homeless Persons Health Project | Mental Health Client Action Network |
| Housing Matters | Mountain Community Resources |
| Pajaro Rescue Mission | Salud Para La Gente |
| Pajaro Valley Shelter Services | Santa Cruz Community Health Centers |
| Salvation Army (Watsonville) | Santa Cruz Public Libraries |
| Santa Cruz County Human Services Department- CHAMP | Whole Person Care Program |
| Veterans Resource Center | Wings Homeless Advocacy |
| Adult and Long Term Care | County HSD Youth Coordinated Entry |
| Adult Protective Services | Bill Wilson Center San Jose |
| Behavioral Health | The Housing Authority County Santa Cruz |

Participation in the HMIS program is important to our community's ability to provide you with the best services and housing possible. As you receive services, information will be collected about you, the services provided to you, and the outcomes these services help you to achieve. Your name and other identifying information will not be shared with any agency not participating in the system (unless required to do so by law.) Authorizing your information to be entered into the HMIS is voluntary. Refusing to do so will not limit your access to shelter or services.

I give authorization for my basic and relevant information to be entered _____ **(please initial)** and shared _____ **(please initial)** between Partner Agencies in order to help assist me in obtaining permanent housing, employment, financial assistance, vocational services, counseling and medical/mental health treatment and for research and administrative purposes. (Basic information includes intake date, name, social security number, gender, birth date, ethnicity, marital status, number in household, military status, primary language spoken, and non-confidential services requested and received.) I understand that I have the right to receive a copy of all information shared between the Partner Agencies.

I understand that the current list of participating Partner Agencies may change over time to include other agencies who provide housing or services to the homeless population, and I give authorization for my information to be shared with any new Partner Agency. _____ **(please initial)**

I understand that I may request a current list of all Partner Agencies at any time. I understand that I may cancel this authorization at any time by written request, but that the cancellation will not be retroactive. I understand that this release is valid for three years from the date of my signature below.

Print Name of Client or Guardian

Signature Of Client Or Guardian

Date

Note: A separate, HIPAA-compliant authorization is required for disclosure of any patient health information, including mental health and drug and alcohol information protected by any State or Federal privacy law including, but not limited to, Health Insurance Portability and Accountability Act ("HIPAA"), 45 C.F.R. parts 160 and 164, California Confidentiality of Medical Information Act ("CMIA"), Civil Code sections 56-56.16, Welfare and Institutions Code section 5328, or 42 C.F.R part 2.1, et seq.



Date _____

Assessing Agency Information

Assessing Agency Name: _____

Agency Address: _____

City: _____ State: _____ Zip code: _____

Staff Phone #1: _____

Staff Phone #2: _____

Staff E-mail Address:

_____ Alternative Staff

Member: _____ Alternative Staff

Phone #1: _____

Alternative Staff Phone #2: _____

Alternative Staff E-mail Address: _____

Client 4-Digit Identifier: _____

Client Veteran Status: Yes No

Date ____/____/____

Smart Path Additional Questions

First Name _____ **Middle** _____

Last Name _____

1. How long has it been since you've lived in permanent stable housing?

2. Are you expecting any changes in your family structure?

Yes No

Comment:

3. Do you currently have an open child welfare case in Santa Cruz County?

Yes No

4. Are you working with a case manager at any agency?

Yes No

a. If so, what is the name of the agency and case manager?

Agency: _____ Case Manager: _____

HMIS # _____
Staff Name _____
Date Form Completed ____ / ____ / ____

Santa Cruz County Standard Intake - Client Profile

The service provider should complete this form while interviewing a client. *A separate Intake Client Profile is completed for each member of the household, including children.*

<p>1) Relationship to HoH (HUD)</p> <p><i>Single individuals are also heads of household (HoH). In multiple person households one person must be designated head of household</i></p> <p>1a) Relationship to HoH – Additional Detail</p>	<p><input type="checkbox"/> Self (HoH)</p> <p><input type="checkbox"/> Child of HoH</p> <p><input type="checkbox"/> Spouse/partner of HoH</p> <p><input type="checkbox"/> Relative member of household</p> <p><input type="checkbox"/> Non-relative member of household</p> <hr/> <p><input type="checkbox"/> Self</p> <p><input type="checkbox"/> Husband/Wife</p> <p><input type="checkbox"/> Son/Daughter</p> <p><input type="checkbox"/> Father/Mother</p> <p><input type="checkbox"/> Sister/Brother</p> <p><input type="checkbox"/> Roommate</p> <p><input type="checkbox"/> Grandchild</p> <p><input type="checkbox"/> Aunt/Uncle</p> <p><input type="checkbox"/> Niece/Nephew</p> <p><input type="checkbox"/> Grandparent</p> <p><input type="checkbox"/> Significant Other</p> <p><input type="checkbox"/> Domestic Partner</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Stepdaughter/Stepson</p>																	
<p>2) Client Name</p> <p>Quality of Name</p>	<table border="1"> <tr> <td>First</td> <td>Middle</td> </tr> <tr> <td colspan="2">Last</td> </tr> <tr> <td colspan="2">Alias (if multiple, separate by commas)</td> </tr> <tr> <td><input type="checkbox"/> Full Name Reported</td> <td><input type="checkbox"/> Client Doesn't Know</td> </tr> <tr> <td><input type="checkbox"/> Partial Name or Nickname</td> <td><input type="checkbox"/> Client Refused</td> </tr> </table>	First	Middle	Last		Alias (if multiple, separate by commas)		<input type="checkbox"/> Full Name Reported	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Partial Name or Nickname	<input type="checkbox"/> Client Refused							
First	Middle																	
Last																		
Alias (if multiple, separate by commas)																		
<input type="checkbox"/> Full Name Reported	<input type="checkbox"/> Client Doesn't Know																	
<input type="checkbox"/> Partial Name or Nickname	<input type="checkbox"/> Client Refused																	
<p>3) Social Security Number (SSN)</p> <p><i>Please verify this SSN is the same as the one in HMIS.</i></p> <p>Quality of Social Security Number</p>	<table border="1"> <tr> <td> <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"/> <input type="text"/> <input type="text"/> </td> </tr> <tr> <td> <input type="checkbox"/> Full SSN Reported <input type="checkbox"/> Approximate or Partial SSN </td> <td> <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused </td> </tr> </table>	<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"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Full SSN Reported <input type="checkbox"/> Approximate or Partial SSN	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused														
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<input type="checkbox"/> Full SSN Reported <input type="checkbox"/> Approximate or Partial SSN	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused																	
<p>4) Date of Birth (DOB)</p> <p>Quality of Date of Birth</p>	<table border="1"> <tr> <td> <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"/> </td> <td> / </td> <td> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </td> <td> / </td> <td> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </td> </tr> <tr> <td>Month</td> <td></td> <td>Day</td> <td></td> <td>Year</td> <td></td> </tr> <tr> <td colspan="2"> <input type="checkbox"/> Full DOB Reported <input type="checkbox"/> Approximate or Partial DOB </td> <td colspan="4"> <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused </td> </tr> </table>	<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"/>	/	<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"/> <input type="text"/> <input type="text"/>	Month		Day		Year		<input type="checkbox"/> Full DOB Reported <input type="checkbox"/> Approximate or Partial DOB		<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused			
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Month		Day		Year														
<input type="checkbox"/> Full DOB Reported <input type="checkbox"/> Approximate or Partial DOB		<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused																

<p>5) Gender</p> <p><i>Which of these genders best describes how the client identifies?</i></p>	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> A gender other than singularly female or male (e.g., non-binary, genderfluid, agender, culturally specific gender) <input type="checkbox"/> Transgender <input type="checkbox"/> Questioning <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused				
<p>6) Race (Required)</p> <p><i>What race or races best describe how the client identifies? Check all that apply</i></p>	<input type="checkbox"/> American Indian, Alaska Native, Indigenous <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black, African American, or African <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused				
<p>7) Ethnicity (Required)</p> <p><i>What ethnicity best describes how the client identifies?</i></p>	<input type="checkbox"/> Non-Hispanic/Non-Latin(a)(o)(x) <input type="checkbox"/> Hispanic/Latin(a)(o)(x) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused				
<p>8) Veteran Status</p> <p><i>Is the client a veteran of the US armed forces? Was he/she ever on active duty in the military?</i></p> <p><i>If the answer is "no", skip to the "Client Enrollment" section</i></p> <p><i>If the answer is "yes", COMPLETE questions 8 through 12.</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused				
<p>9) Year Entered Military Service</p>	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> <p style="text-align: center;">Year</p>				
<p>10) Year Separated from Military Service</p>	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> <p style="text-align: center;">Year</p>				

11) Theater of Operations Served:	<i>In what theater or theaters of operation was client active?</i>	
World War II	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Korean War	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Vietnam War	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Persian Gulf War (Desert Storm)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Afghanistan (Operation Enduring Freedom)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Iraq (Iraqi Freedom)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Iraq (New Dawn)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Other Operations Other peace-keeping operations or military interventions (such as Lebanon, Panama, Somalia, Bosnia, Kosovo)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Branch of Military	<input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Navy <input type="checkbox"/> Marine	<input type="checkbox"/> Coast Guard <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Discharge Status	<input type="checkbox"/> Honorable <input type="checkbox"/> General Under Honorable Conditions <input type="checkbox"/> Under Other Than Honorable Conditions (OTH) <input type="checkbox"/> Bad Conduct	<input type="checkbox"/> Dishonorable <input type="checkbox"/> Uncharacterized <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused

Client Name	_____
HMIS #	_____
Staff Name	_____
Date Form Completed	_____

Santa Cruz County Standard Contacts Form

Client Contact Information

Client Name	First	Last
Contact Type	<input type="checkbox"/> Self	
Phone (#1)		
Phone (#2)		
Email Address		
Street Address	Address	City
Date Information Collected	State	Zip Code
Note		

Emergency Contact Information

Name	First	Last
Contact Type	<input type="checkbox"/> Emergency Contact	
Phone (#1)		
Phone (#2)		
Email Address		
Street Address	Address	City
Date Information Collected	State	Zip Code
Note		

Head of Household Name (if not Self) _____

Care/Case Manager Contact Information

Name	First	Last
Contact Type	<input type="checkbox"/> Care/Case Manager Care/Case Management Agency:	
Phone (#1)		
Phone (#2)		
Email Address		
Street Address	Address	City
	State	Zip Code
Date Information Collected		
Note		

Primary Care Provider Contact Information

Name	First	Last
Contact Type	<input type="checkbox"/> Primary Care Provider	
Phone (#1)		
Phone (#2)		
Email Address		
Street Address	Address	City
	State	Zip Code
Date Information Collected		
Note		

Head of Household Name (if not Self) _____

Other Contact Information

Name	First	Last
Contact Type	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Spouse	<input type="checkbox"/> Benefits Advocate <input type="checkbox"/> Real Estate Partnership Contact <input type="checkbox"/> Other
Phone (#1)		
Phone (#2)		
Email Address		
Street Address	Address	City
	State	Zip Code
Date Information Collected		
Note		

Other Contact Information

Name	First	Last
Contact Type	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Spouse	<input type="checkbox"/> Benefits Advocate <input type="checkbox"/> Real Estate Partnership Contact <input type="checkbox"/> Other
Phone (#1)		
Phone (#2)		
Email Address		
Street Address	Address	City
	State	Zip Code
Date Information Collected		
Note		

Head of Household Name (if not Self) _____

HMIS # _____
Staff Name _____
Date Form Completed ____ / ____ / ____

Santa Cruz County HMIS Standard Enrollment

The service provider should complete this form while interviewing a client. *A separate Enrollment Form is completed for each member of the household, including children.*

1) Client Name	First Last																				
2) Date of Program Enrollment <i>The date the client started being helped by the project (program); also called the project start date.</i>	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;">/</td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;">/</td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td> </tr> <tr> <td colspan="3">Month</td> <td colspan="3">Day</td> <td colspan="4">Year</td> </tr> </table>			/			/					Month			Day			Year			
		/			/																
Month			Day			Year															
3) Housing Move-In Date: <i>(Required for Permanent Housing Projects)</i> <i>This is the date a client moves into a permanent housing situation while enrolled in Rapid Rehousing, Permanent Supportive Housing or Other Permanent Housing programs, even if the move-in date is the same as the project enrollment date.</i>	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;">/</td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;">/</td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td> </tr> <tr> <td colspan="3">Month</td> <td colspan="3">Day</td> <td colspan="4">Year</td> </tr> </table>			/			/					Month			Day			Year			
		/			/																
Month			Day			Year															
4) Date of Engagement <i>(only for Street Outreach or Night-by-Night Emergency Shelter)</i> <i>The date the client relationship results in a collaboratively developed action plan with a provider.</i>	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;">/</td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;">/</td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td> </tr> <tr> <td colspan="3">Month</td> <td colspan="3">Day</td> <td colspan="4">Year</td> </tr> </table>			/			/					Month			Day			Year			
		/			/																
Month			Day			Year															

Client Name _____

Head of Household Name (if not Self) _____

<p>5) Prior Living Situation <i>What was the client's living situation the night before enrolling in the project?</i></p> <p><i>Ask the client "where did you stay or sleep last night"?</i></p>	<p><u>Homeless Situations</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Place not meant for human habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport/or anywhere outside) <input type="checkbox"/> Emergency Shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter <input type="checkbox"/> Safe Haven <p><u>Institutional Situations</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non—psychiatric medical facility <input type="checkbox"/> Jail, prison or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center <p><u>Transitional & Permanent Housing Situations</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Hotel or motel Paid for without emergency shelter voucher <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Staying or living in a friend's room, apartment or house <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> Rental by client with GPD TIP housing subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons <input type="checkbox"/> Rental by client, with RRH or equivalent subsidy <input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based) <input type="checkbox"/> Rental by client in a public housing unit <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy <p><u>Other</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
<p>6) Length of stay in prior living situation <i>How long have you been sleeping/staying where you stayed/slept last night? If the client has stayed in similar situations (e.g., outside, homes of friends) but not exactly the same PLACE, include the total time in that type of situation.</i></p>	<ul style="list-style-type: none"> <input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> One month or more, but less than 90 days <input type="checkbox"/> 90 days or more, but less than one year <input type="checkbox"/> One year or longer <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused

Client Name _____

Head of Household Name (if not Self) _____

<p>7) If the client stayed in an Institutional Situation last night, was the stay less than 90 days?</p> <p>If the response is “Yes”, did the client stay on the streets or in emergency shelter the night before going to the institutional situation?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>8) If the client stayed in Transitional/Permanent housing last night, was the stay less than 7 days?</p> <p>If the response is “Yes”, did the client stay on the streets or in emergency shelter the night before going to the transitional or permanent placement?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>9) Approximate date <u>this</u> current homeless situation began:</p> <p><i>When was the date the current homeless situation began?</i></p> <p><i>A break in homelessness is defined as being off the street or out of shelter for 7 days or more or spending 90 days or more in an institution.</i></p>	<p><input type="checkbox"/> Not Applicable</p> <p style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> </p> <p style="color: red; text-align: center;">This information can be by client self-report</p>
<p>10) Number of times the client has been on the streets or in Emergency Shelter in the <u>past three years</u> including today</p>	<p><input type="checkbox"/> One 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</p>
<p>11) Total number of months client has been on the streets or in Emergency Shelter in the <u>past three years</u></p>	<p><input type="checkbox"/> One month (this time is the first month) <input type="checkbox"/> 12 months <input type="checkbox"/> 2 months <input type="checkbox"/> 7 months <input type="checkbox"/> 3 months <input type="checkbox"/> 8 months <input type="checkbox"/> 4 months <input type="checkbox"/> 9 months <input type="checkbox"/> 5 months <input type="checkbox"/> 10 months <input type="checkbox"/> 6 months <input type="checkbox"/> 11 months <input type="checkbox"/> More than 12 months <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused</p>

Client Name _____

Head of Household Name (if not Self) _____

Disabling Conditions (All Responses required)

<p>1) Does the client currently have a disabling condition? <i>A Disabling Condition is a health condition that interferes with getting and/or keeping stable housing.</i></p> <p><i>This question is used with other information to determine if the client meets criteria for chronic homelessness.</i></p> <p>All questions in this section MUST be answered even if the answer is “no” to this question.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>
<p>2) Does the client have a Physical Disability?</p> <p><i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>
<p>3) Does the client have a Developmental Disability?</p> <p><i>If Yes, is it expected to substantially impair the client's ability to live independently?</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>
<p>4) Does the client have a Chronic Health Condition?</p> <p><i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>
<p>5) Does the client have HIV – AIDS?</p> <p><i>If Yes, is it expected to substantially impair the client's ability to live independently?</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused</p>

Client Name _____

Head of Household Name (if not Self) _____

<p>6) Does the client have a Mental Health Disorder?</p> <p><i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i></p>	<table> <tr> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> Client Doesn't Know</td> </tr> <tr> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Client Refused</td> </tr> <tr style="background-color: #cccccc;"> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> Client Doesn't Know</td> </tr> <tr style="background-color: #cccccc;"> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Client Refused</td> </tr> </table>	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> No	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> No	<input type="checkbox"/> Client Refused				
<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know												
<input type="checkbox"/> No	<input type="checkbox"/> Client Refused												
<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know												
<input type="checkbox"/> No	<input type="checkbox"/> Client Refused												
<p>7) Does the client have any Substance Use Disorder?</p> <p><i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i></p>	<table> <tr> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Client Doesn't Know</td> </tr> <tr> <td><input type="checkbox"/> Alcohol use disorder</td> <td><input type="checkbox"/> Client Refused</td> </tr> <tr> <td><input type="checkbox"/> Drug use disorder</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Both Alcohol & Drug Abuse Use Disorders</td> <td></td> </tr> <tr style="background-color: #cccccc;"> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> Client Doesn't Know</td> </tr> <tr style="background-color: #cccccc;"> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Client Refused</td> </tr> </table>	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Alcohol use disorder	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Drug use disorder		<input type="checkbox"/> Both Alcohol & Drug Abuse Use Disorders		<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> No	<input type="checkbox"/> Client Refused
<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know												
<input type="checkbox"/> Alcohol use disorder	<input type="checkbox"/> Client Refused												
<input type="checkbox"/> Drug use disorder													
<input type="checkbox"/> Both Alcohol & Drug Abuse Use Disorders													
<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know												
<input type="checkbox"/> No	<input type="checkbox"/> Client Refused												

Domestic Violence

<p>1) Domestic Violence Victim/Survivor</p> <p><i>Ask the client "Have you ever experienced any domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions against you or a member of your family, including a child, that has happened in the place you were living?"</i></p> <hr/> <p><i>If the answer is "no", skip to "Monthly Income – Cash Benefits" section.</i></p> <p><i>If the answer is "yes", COMPLETE questions 2 and 3.</i></p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	
<p>2) Most Recent Occurrence</p> <p><i>Ask the client "How long ago was your most recent experience of domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions?"</i></p>	<p><input type="checkbox"/> Within the past three months</p> <p><input type="checkbox"/> Three to six months ago (excluding six months exactly)</p> <p><input type="checkbox"/> Six months to one year ago (excluding one year exactly)</p> <p><input type="checkbox"/> One year ago or more</p> <p><input type="checkbox"/> Client Doesn't Know</p> <p><input type="checkbox"/> Client Refused</p>	
<p>3) Current Status</p> <p><i>Ask the client "Are you currently fleeing, or attempting to flee, the domestic violence situation, or are you afraid to return to the place you are living?"</i></p>	<p><input type="checkbox"/> Yes</p>	<input type="checkbox"/> Client Doesn't Know
	<input type="checkbox"/> No	<input type="checkbox"/> Client Refused

Client Name _____

Head of Household Name (if not Self) _____

Monthly Income – Cash Benefits

<p>Current income from any source? <i>Is the client currently receiving any income from any source?</i></p> <p>Specify the type(s) and amount(s) of income the client currently receives.</p> <p><i>Only regular, recurrent sources that are current today should be included. Income received for a minor (under 18 years old) member of the household (e.g., SSI) should be recorded with the HoH's information.</i></p> <p><i>DO NOT include income received by other adults (18 years and older) in the household; record their income on their Enrollment form.</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused</p> <hr/> <p><input type="checkbox"/> Earned Income \$ _____</p> <p><input type="checkbox"/> Unemployment Insurance \$ _____</p> <p><input type="checkbox"/> Supplemental Security Income SSI \$ _____</p> <p><input type="checkbox"/> Social Security Disability Insurance SSDI \$ _____</p> <p><input type="checkbox"/> VA Service-Connected Disability Pension \$ _____</p> <p><input type="checkbox"/> VA Non-service connect disability pension \$ _____</p> <p><input type="checkbox"/> Private Disability Insurance \$ _____</p> <p><input type="checkbox"/> Worker's Compensation \$ _____</p> <p><input type="checkbox"/> Temporary Assistance for Needy Families TANF/CalWORKs \$ _____</p> <p><input type="checkbox"/> General Assistance (GA) \$ _____</p> <p><input type="checkbox"/> Retirement income from Social Security \$ _____</p> <p><input type="checkbox"/> Pension or Retirement Income from a Former Job \$ _____</p> <p><input type="checkbox"/> Child Support \$ _____</p> <p><input type="checkbox"/> Alimony and Other Spousal Support \$ _____</p> <p><input type="checkbox"/> Other Cash Income \$ _____</p> <p>If Other Specify: _____</p>
<p>Total Cash Income for Individual</p>	<p>TOTAL: \$ _____</p>

Non-Cash Benefits

<p>Currently receiving Non-Cash Benefits? <i>Is the client currently receiving one of the non-cash benefits listed below?</i></p> <p>If Yes, indicate all the non-cash benefits the client is receiving:</p> <p><i>Only regular, recurrent sources that are current today should be included. Record non-cash benefits received by a minor member (under 18 years of age) of the household under the HoH's information.</i></p> <p><i>DO NOT include benefits received by other adults (18 years and older) in the household; record their benefits on their Enrollment form.</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused</p> <hr/> <p><input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP)/Cal Fresh</p> <p><input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)</p> <p><input type="checkbox"/> TANF/CALWORKS Childcare Services</p> <p><input type="checkbox"/> TANF/CALWORKS Transportation Services</p> <p><input type="checkbox"/> Other TANF/CALWORKS-Funded Services</p> <p><input type="checkbox"/> Other Non-Cash Benefit</p> <p>If Other Specify: _____</p>
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Client Name _____

Head of Household Name (if not Self) _____

Health Insurance

<p>Currently covered by health insurance? <i>Is the client currently covered by health insurance?</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
<p>If Yes, type(s) of insurance(s): <i>If the client is currently covered by multiple health insurances please select all that apply.</i></p>	<input type="checkbox"/> Medicaid (same as Medi-Cal) <input type="checkbox"/> Medicare <input type="checkbox"/> State Children's Health Insurance (CHIP) Program <input type="checkbox"/> Veteran's Administration (VA) Medical Services <input type="checkbox"/> Employer-Provided Health Insurance <input type="checkbox"/> Health Insurance Obtained Through COBRA <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Other Health Insurance If Other Specify: _____

Well-Being and General Health Status (Head of Household Only)

<p>1) Client perceives their life has value and worth.</p>	<input type="checkbox"/> Strongly Disagree <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Somewhat disagree <input type="checkbox"/> Client Refused <input type="checkbox"/> Neither Agree or Disagree <input type="checkbox"/> Somewhat Agree <input type="checkbox"/> Strongly Agree
<p>2) Client perceives they have support from others who will listen to problems.</p>	<input type="checkbox"/> Strongly Disagree <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Somewhat disagree <input type="checkbox"/> Client Refused <input type="checkbox"/> Neither Agree or Disagree <input type="checkbox"/> Somewhat Agree <input type="checkbox"/> Strongly Agree
<p>3) Client perceives they have a tendency to bounce back after hard times.</p>	<input type="checkbox"/> Strongly Disagree <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Somewhat disagree <input type="checkbox"/> Client Refused <input type="checkbox"/> Neither Agree or Disagree <input type="checkbox"/> Somewhat Agree <input type="checkbox"/> Strongly Agree
<p>4) Client's frequency of feeling nervous, tense, worried, frustrated, or afraid.</p>	<input type="checkbox"/> Not at all <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Once a month <input type="checkbox"/> Client Refused <input type="checkbox"/> Several times a month <input type="checkbox"/> Several times a week <input type="checkbox"/> At least every day

Client Name _____

Head of Household Name (if not Self) _____

5) Clients' general health status.	<input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very Good <input type="checkbox"/> Excellent	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
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Employment Status

Currently Employed? <i>Is the client currently employed?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
If Yes, specify the type of employment	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Seasonal/Sporadic (including day labor)	
If No, is the client looking for employment?	<input type="checkbox"/> Looking for work <input type="checkbox"/> Unable to work <input type="checkbox"/> Not looking for work	

Education Status

Specify the last grade of school completed by the client	<input type="checkbox"/> Less than Grade 5 <input type="checkbox"/> Grades 5-6 <input type="checkbox"/> Grades 7-8 <input type="checkbox"/> Grades 9-11 <input type="checkbox"/> Grade 12/ High school diploma <input type="checkbox"/> School program does not have grade levels	<input type="checkbox"/> GED <input type="checkbox"/> Some college <input type="checkbox"/> Associate's degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Graduate degree <input type="checkbox"/> Vocational certification <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Is the client currently enrolled in school or a training program?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
If Yes, specify the type of school or training program	<input type="checkbox"/> Kindergarten – 8 th grade <input type="checkbox"/> High School <input type="checkbox"/> Community College <input type="checkbox"/> Vocational Program	<input type="checkbox"/> Training Program <input type="checkbox"/> University <input type="checkbox"/> Other

Last Permanent Address

<u>This is the address of the client's last permanent housing prior to this experience of homelessness: not the address of a shelter or a location not meant for human habitation like the streets or a park.</u>	Street Address	City
	State	Zip Code

Client Name _____

Head of Household Name (if not Self) _____

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

SCORE:

VULNERABILITY INDEX - SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL (VI-SPDAT)

SINGLE ADULTS

AMERICAN VERSION 2.01

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

Follow-Up Questions

On a regular day, where is it easiest to find you and what time of day is easiest to do so?	place: _____ time: ___ : ___ or _____
Is there a phone number and/or email where someone can safely get in touch with you or leave you a message?	phone: (____) _____ - _____ email: _____
Ok, now I'd like to take your picture so that it is easier to find you and confirm your identity in the future. May I do so?	<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
- legal status in country
- children that may reside with the adult at some point in the future
- ageing out of care
- income and source of it
- safety planning
- mobility issues
- current restrictions on where a person can legally reside



Assessment Specialist

Field for the Assessment Specialist, not a required field:

1. There are significant concerns with this VI-SPDAT score. It is suggested that a full SPDAT be conducted should this client be referred to a housing program.

This score seems significantly high. This score seems significantly low.

Comment:

2. Is this client a participant in the Dignity Health Passport to Health High Utilizer Program?

Yes No

Smart Path Non-Housing Resources

Select all categories of non-housing resources to which you referred the participant:

- Basic Needs (meals, food pantry, clothing, showers, emergency shelter)
- Health Services (medical services, mental health services, dental services, substance use disorder services)
- Government Benefits (Medi-Cal, SSI, General Assistance, TANF, CalFresh)
- Other (employment programs, personal identification (ID, birth certificate, Social Security Card), free phone, mail services, transportation (bus passes))

