

MSHMIS HARA Screening Assessment

HOUSEHOLD INFORMATION						
Answer this section for all persons in household (use additional sheets for larger families)						
Full Name	Relationship to Head of Household	SSN	US Military Veteran	Date of Birth mm/dd/yyyy	Gender	Race <i>(Select all that apply)</i>
<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <p><u>Name Data Quality</u></p> <input type="checkbox"/> Full name <input type="checkbox"/> Partial, street or code name <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Self (Head of household)	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <p><u>SSN Data Quality</u></p> <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	<p style="color: red; font-style: italic;">(Answer for adults 18+ only)</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<div style="text-align: center; margin-bottom: 5px;">/ /</div> <p><u>DOB Data Quality</u></p> <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	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Trans Female (MTF or Male to Female) <input type="checkbox"/> Trans Male (FTM or Female to Male) <input type="checkbox"/> Gender Non Conforming <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <p><u>Name Data Quality</u></p> <input type="checkbox"/> Full name <input type="checkbox"/> Partial, street or code name <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Head of Household's child <input type="checkbox"/> Head of household's spouse or partner <input type="checkbox"/> Head of household's other relation member (other relation to head of household) <input type="checkbox"/> Other: non-relation member	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <p><u>SSN Data Quality</u></p> <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	<p style="color: red; font-style: italic;">(Answer for adults 18+ only)</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<div style="text-align: center; margin-bottom: 5px;">/ /</div> <p><u>DOB Data Quality</u></p> <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	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Trans Female (MTF or Male to Female) <input type="checkbox"/> Trans Male (FTM or Female to Male) <input type="checkbox"/> Gender Non Conforming <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
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HOUSEHOLD INFORMATION continued...

Answer this section for all persons in household (use additional sheets for larger families)

Name <i>(Answer for All Persons in HH)</i>	Ethnicity	Does the client have a disabling condition?	If client has a disabling condition, please answer the following sub-assessment questions:			
			Disability Type <i>(Select all that apply)</i>	Disability Determination	If Yes, to be long-continued and indefinite duration and substantially impairs ability to live independently?	Long Term <i>(Yes/No)</i>
	<input type="checkbox"/> Non- Hispanic/ Non-Latino <input type="checkbox"/> Hispanic/ Latino <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't Know <input type="checkbox"/> Client refused	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problems <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Non- Hispanic/ Non-Latino <input type="checkbox"/> Hispanic/ Latino <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't Know <input type="checkbox"/> Client refused	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problems <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Non- Hispanic/ Non-Latino <input type="checkbox"/> Hispanic/ Latino <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't Know <input type="checkbox"/> Client refused	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problems <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No

Homeless History Interview

Answer the following questions for ALL Household Members

(Use additional sheets if members of the same household have different homeless histories)

Chronic status is determined by a client's history of homelessness, disability status, and the length of time spent on the street, in an emergency shelter or safe haven. Requires a substantiated disability and, continuously homeless for past 12 months to qualify or 4 separate occasions in the past 3 years as long as the combined occasions total at least 12 months. Intake workers should not instruct the client on the length of time/# of episodes necessary to qualify as chronically homeless. Questions should be asked in the exact order they are presented below.

Describe the client's living situation (immediately) prior to project entry?

(Select one Living Situation and answer the corresponding questions in the order in which they appear)

	Literally Homeless Situation	Institutional Situation	Transitional/Permanent Housing Situation	Don't Know/ Refused
SECTION I	<input type="checkbox"/> Place not meant for habitation (e.g. a vehicle, abandoned building, bus/train/subway station, airport, anywhere outside). <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher. <input type="checkbox"/> Safe Haven <input type="checkbox"/> Interim Housing (e.g. client applied for permanent housing and a unit/voucher has been reserved but client is not able to move in immediately).	<input type="checkbox"/> Foster care home or foster 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	<input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons (such as CoC Project) <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Rental by client, with GPD TIP subsidy <input type="checkbox"/> Rental by client, with RRH or equivalent housing subsidy <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> Staying or living in a friend's room, apartment or house <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth)	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused

Housing Status

- Category 1 - Homeless
- Category 2 – At imminent risk of losing housing

- Category 3 – Homeless only under other federal statuses
- Category 4 – Fleeing domestic violence
- At-risk of homelessness
- Stably Housed

- Client doesn't know
- Client refused

Zip Code of Last Permanent Address: _____

City of Residence: _____

County of Residence: _____

****Answer the following questions for HEAD OF HOUSEHOLD Only****

Client Location (CoC Code/Name) _____

Do you have other housing options for the next few days/weeks? Yes No
If yes, how long? _____

If Doubled-Up: Describe Issues & Resource Needs

If Own Unit: Describe Issues & Resources Needs

Number in Household (enter "1" if single adult only):

Household Size: _____ # of Adults _____ # of Children _____

Total Household monthly income _____ % of Median Income: 0-30% 31-50% 51-80% over 80% (Use Median Income Chart)

Prevention Only (Complete this section for Head of Household Only - Skip if Literally Homeless)

What is the monthly rent amount? _____ No of bedrooms: _____

Is back rent/late fees owed? Yes No; If yes: # of Mos. Delinquent: _____ Total Due \$ _____

Is another agency/person/program providing any of the rent costs? Yes (*How Much?*) \$ _____ No

Have eviction proceedings begun? Yes No

If yes, list evidence provided: _____

OPTIONAL List any utilities that are not included in the rent (Phone and Int/TV are not eligible for ESG asst.)

Utility	Monthly Amount	Past Due Balance
Gas		
Electric		
Water		

Emergency Contact Information

To obtain the client's emergency contact information, intake staff should ask the client, "If you wish to be contacted regarding benefits that you may be eligible for or in the case of an emergency, we will need your best Contact Information. Some services are very time limited so please be as accurate as possible and include how we might reach you even as your circumstances are changing."

Client's Cell Phone Number _____

Emergency Contact's Name _____

Contact Type (Relationship to Client) _____

Phone Number _____

Second Phone Number _____

Email Address _____

Contact's Address: Street _____ **City** _____ **State** _____

Contact's Zip Code _____

Assessment Disposition

Required for Head of Household

- Referred to emergency shelter/safe haven
- Referred to transitional housing
- Referred to rapid re-housing
- Referred to permanent supportive housing
- Referred to homeless outreach
- Referred to street outreach
- Referred to other continuum project type
- Referred to a homelessness diversion program
- Unable to refer/accept within continuum; ineligible for continuum projects
- Unable to refer/accept within continuum; continuum services unavailable
- Referred to other community project (non-continuum)
- Applicant denied referral/acceptance
- Applicant terminated assessment prior to completion
- Other/specify