

Mendocino County Homeless Services Continuum of Care

Coordinated Entry Screening Tool

For a multi-person household: Use this form for the Head of Household & complete the CE Additional Household Member form for the other members

FACESHEET: PRE-SCREENING

First Name:			Middle Name:			Last Name:		
<i>Name Data Quality:</i> <input type="checkbox"/> Full name reported <input type="checkbox"/> Partial, street, or code name reported <input type="checkbox"/> Does not know (DNK) <input type="checkbox"/> Refused (RFSD) <input type="checkbox"/> Data not collected (DNC)								
Alias:				Social Security Number: _____ - _____ - _____				
<i>SSN Data Quality:</i> <input type="checkbox"/> Full SSN reported <input type="checkbox"/> Approximate or partial SSN reported <input type="checkbox"/> DNK <input type="checkbox"/> RFSD <input type="checkbox"/> DNC								
Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DNK <input type="checkbox"/> RFSD <input type="checkbox"/> DNC				Screening Type: HUD		Client Location: CA-509		
Date of Birth:		Age:	What language are you best able to express yourself in?					
<i>Date of Birth Type:</i> <input type="checkbox"/> Full DoB reported <input type="checkbox"/> Approximate or partial DoB reported <input type="checkbox"/> DNK <input type="checkbox"/> RFSD <input type="checkbox"/> DNC								
Relationship to Head of Household: Self (<i>this tool is used for the Head of Household</i>)								
1. PRIOR LIVING SITUATION – Where were you sleeping the night before you were screened for Coordinated Entry?								
Homeless Situations:		<input type="checkbox"/> Place not meant for habitation <input type="checkbox"/> Safe Haven			<input type="checkbox"/> Emergency shelter, including hotel/motel paid for with emergency shelter voucher			
Institutional Situations:		<input type="checkbox"/> Foster care home or group home <input type="checkbox"/> Hospital: non-psychiatric <input type="checkbox"/> Jail, prison, juvenile detention			<input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital/facility <input type="checkbox"/> Substance abuse treatment facility			
Temporary/Permanent Situations:		<input type="checkbox"/> Residential project or halfway house w/o homeless criteria <input type="checkbox"/> Hotel/motel paid for w/o emergency shelter voucher <input type="checkbox"/> Transitional housing for homeless persons <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Staying w/ family <input type="checkbox"/> Staying w/ friends <input type="checkbox"/> Rental by client, w/ GPD TIP subsidy <input type="checkbox"/> Rental by client, w/ VASH subsidy			<input type="checkbox"/> Permanent housing for formerly homeless persons <input type="checkbox"/> Rental by client, w/ RRH subsidy <input type="checkbox"/> Rental by client, w/ HCV subsidy <input type="checkbox"/> Rental by client, in public housing unit <input type="checkbox"/> Rental by client, no ongoing subsidy <input type="checkbox"/> Rental by client, w/ other subsidy <input type="checkbox"/> Owned by client, no ongoing subsidy <input type="checkbox"/> Owned by client, w/ ongoing subsidy <input type="checkbox"/> DNK <input type="checkbox"/> RFSD <input type="checkbox"/> DNC			
How many nights did you sleep in that location? # _____		<i>If less than 90 nights in an institutional setting: did you stay on the streets or in an emergency shelter on the night before the most recent location?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No						
2. DURATION OF HOMELESSNESS								
Date your homelessness started this time: _____/_____/_____								
Number of separate times on the street or in shelter in the past three years: # _____ Times								
Total numbers of months spent on the street or in emergency shelter in the past three years: # _____ Months								
3. CURRENT LIVING SITUATION – Where are you sleeping right now or where will you sleep tonight?								
Homeless Situations:		<input type="checkbox"/> Place not meant for habitation <input type="checkbox"/> Safe Haven			<input type="checkbox"/> Emergency shelter, including hotel/motel paid for with emergency shelter voucher			
Institutional Situations:		<input type="checkbox"/> Foster care home or group home <input type="checkbox"/> Hospital: non-psychiatric <input type="checkbox"/> Jail, prison, juvenile detention			<input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital/facility <input type="checkbox"/> Substance abuse treatment facility			

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Temporary/Permanent Situations:	<input type="checkbox"/> Residential project or halfway house w/o homeless criteria <input type="checkbox"/> Hotel/motel paid for w/o emergency shelter voucher <input type="checkbox"/> Transitional housing for homeless persons <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Staying w/ family <input type="checkbox"/> Staying w/ friends <input type="checkbox"/> Rental by client, w/ GPD TIP subsidy <input type="checkbox"/> Rental by client, w/ VASH subsidy	<input type="checkbox"/> Permanent housing for homeless persons <input type="checkbox"/> Rental by client, w/ RRH subsidy <input type="checkbox"/> Rental by client, w/ HCV subsidy <input type="checkbox"/> Rental by client, in public housing unit <input type="checkbox"/> Rental by client, no ongoing subsidy <input type="checkbox"/> Rental by client, w/ other subsidy <input type="checkbox"/> Owned by client, no ongoing subsidy <input type="checkbox"/> Owned by client, w/ ongoing subsidy <input type="checkbox"/> Worker unable to determine <input type="checkbox"/> DNK <input type="checkbox"/> RFSD <input type="checkbox"/> DNC
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Date you started staying at this location:	Living Situation Verified By (CE Agency/Program):
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Are you going to have to leave your current living situation within 14 days? Yes No DNK RFSD DNC

If "Yes" answer the following questions:

- Have you identified a permanent place to move to? Yes No DNK RFSD DNC
- Do you have resources or support networks to obtain permanent housing? Yes No DNK RFSD DNC
- Have you had a lease, rental agreement, or other official/legal ownership interest in a permanent housing unit in the last 60 days? Yes No DNK RFSD DNC
- Have you moved 2 or more times in the last 60 days? Yes No DNK RFSD DNC

Current location details (*notes about where the location is; address; shelter name; etc.*):

GENERAL & LOCAL PRIORITIZATION INFORMATION

4. DEMOGRAPHICS

Primary Race: American Indian/Alaska Native Asian Black/African American Hawaiian/Pacific Islander White
 DNK RFSD DNC

Secondary Race (if applicable): American Indian/Alaska Native Asian Black/African American Hawaiian/Pacific Islander
 White DNK RFSD DNC

Are you: Non-Hispanic/Latino Hispanic/Latino DNK RFSD DNC

What is your gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> TG-male to female <input type="checkbox"/> TG-female to male <input type="checkbox"/> Gender Non-Conforming <input type="checkbox"/> DNK <input type="checkbox"/> RFSD <input type="checkbox"/> DNC	Do you identify as LGBTQ+? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DNK <input type="checkbox"/> RFSD <input type="checkbox"/> DNC
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5. INCOME (*only needed for Head of Household and adult household members*)

Do you have income from any source? Yes No DNK RFSD DNC

If YES, please indicate type/amount below:

<input type="checkbox"/> Alimony/Spousal Support \$ _____	<input type="checkbox"/> Pension/retirement from job \$ _____	<input type="checkbox"/> TANF \$ _____
<input type="checkbox"/> Child Support \$ _____	<input type="checkbox"/> Private Disability Insurance \$ _____	<input type="checkbox"/> Unemployment Ins. \$ _____
<input type="checkbox"/> Earned Income \$ _____	<input type="checkbox"/> Retirement from Social Sec. \$ _____	<input type="checkbox"/> VA Non-serv Pension \$ _____
<input type="checkbox"/> General Assistance \$ _____	<input type="checkbox"/> SSDI \$ _____	<input type="checkbox"/> VA Service Compen. \$ _____
<input type="checkbox"/> Other \$ _____	<input type="checkbox"/> SSI \$ _____	<input type="checkbox"/> Worker's Comp. \$ _____

Total Monthly Income: _____

Do you receive non-cash benefits from any other source? Yes No DNK RFSD DNC

If YES, please indicate type/amount below:

<input type="checkbox"/> Food Stamps \$ _____	<input type="checkbox"/> TANF Child Care Services \$ _____	<input type="checkbox"/> Other TANF-Funded Services \$ _____
<input type="checkbox"/> SSNP for WIC & _____	<input type="checkbox"/> TANF Transportation Services \$ _____	<input type="checkbox"/> Other Source \$ _____

6. HEALTH INFORMATION

Do you have health insurance? Yes No DNK RFSD DNC *If YES, please indicate type:*

<input type="checkbox"/> MEDICAID	<input type="checkbox"/> VA Medical Services	<input type="checkbox"/> Private Pay	<input type="checkbox"/> Indian Health Services Program
<input type="checkbox"/> MEDICARE	<input type="checkbox"/> Employer Provided	<input type="checkbox"/> State HI for Adults	<input type="checkbox"/> Other
<input type="checkbox"/> State Children's HI Program	<input type="checkbox"/> Obtained through COBRA		

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Do you have a disabling condition: Yes No DNK RFSD DNC

Do you live with any of the following? (if the answer to ANY type is YES, the answer to Disabling Condition must be YES)

Disability Type	Yes/No/Does Not Know /Refused/ Data Not Collected	If YES, do you expect this to be long-lasting and of indefinite duration?	Start Date
Alcohol Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DNK <input type="checkbox"/> RFSD <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DNK <input type="checkbox"/> RFSD <input type="checkbox"/> DNC	
Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DNK <input type="checkbox"/> RFSD <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DNK <input type="checkbox"/> RFSD <input type="checkbox"/> DNC	
Chronic Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DNK <input type="checkbox"/> RFSD <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DNK <input type="checkbox"/> RFSD <input type="checkbox"/> DNC	
Developmental Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DNK <input type="checkbox"/> RFSD <input type="checkbox"/> DNC	<input type="checkbox"/> Yes (if yes to disability, will always be yes here)	
Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DNK <input type="checkbox"/> RFSD <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DNK <input type="checkbox"/> RFSD <input type="checkbox"/> DNC	
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DNK <input type="checkbox"/> RFSD <input type="checkbox"/> DNC	<input type="checkbox"/> Yes (if yes to disability, will always be yes here)	
Mental Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DNK <input type="checkbox"/> RFSD <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DNK <input type="checkbox"/> RFSD <input type="checkbox"/> DNC	
Physical Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DNK <input type="checkbox"/> RFSD <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DNK <input type="checkbox"/> RFSD <input type="checkbox"/> DNC	

Notes on any disabilities there was a 'Yes' response to:

7. OTHER (only needed for Head of Household and adult household members)

Phone Number: _____ Email: _____

Residence/Last Permanent Address: _____

Address Data Quality: Full address reported Incomplete or estimated address reported DNK RFSD DNC

Last Perm. Add. Start Date: _____ End Date: _____

Current Mailing Address: _____

What is the BEST way to get ahold of you? _____

Would a past eviction make it challenging for you to get housing? Yes No

Are there other people who would be living with you if you were housed? Yes No Does not know Refused

of adults 18 & older living with you (including yourself) or would be if you were housed? _____ Adults

of children UNDER 18 living with you or would be if you were housed? _____ Children under 18

Is any member of the household age 55 or older? Yes No

Is the Head of Household between 16 to 24 years old? Yes No

Have you ever experienced domestic violence? Yes No Refused

(If YES) When was the most recent occurrence? _____

(If YES) Are you currently fleeing from domestic violence? Yes No Refused

(If YES) Is your experience with domestic violence a contributing factor in your current homelessness situation? Yes No

Does any member of the household have one or more of the following COVID-19 risk factors? Yes No

- | | | |
|--|-----------------------------|---|
| Person is 65 years old or older | Diabetes | Pregnancy |
| Cancer | Down syndrome | Sickle cell disease or hemoglobin disorders |
| Chronic kidney disease | Serious heart conditions | Smoking, current or former |
| Chronic lung diseases or moderate to severe asthma | HIV/AIDS | Solid organ or blood stem cell transplant |
| Dementia or Alzheimer's | Liver disease | Stroke or cerebrovascular disease |
| | Severe obesity (BMI of 40+) | Substance use disorders |

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

This section is only needed for the Head of Household

A. HISTORY OF HOUSING & HOMELESSNESS

1. Where do you sleep most frequently? Shelters Transitional housing Safe Haven Outdoors Other (specify): _____ Refused

IF THE PERSON ANSWERS "OUTDOORS", "OTHER", or "REFUSED": ADD +1

***NOTE: if they answered "hotel" that is counted as "Shelter" IF more than half of the cost is paid for by a service organization, church, or government entity.

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2. How long has it been since you lived in permanent stable housing? _____ Years _____ Months <input type="checkbox"/> Refused	IF THE PERSON HAS EXPERIENCED 1 OR MORE CONSECUTIVE YEARS OF HOMELESSNESS AND/OR 4+ EPISODES OF HOMELESSNESS: ADD +1
3. In the last three (3) years, how many times have you been homeless? (# of separate <u>episodes</u> of homelessness) _____ <input type="checkbox"/> Refused	
B. RISKS	
4. In the past six (6) months (count back 6 months _____), how many times have you...	
a. Received health care at an emergency room? _____ <input type="checkbox"/> Refused	
b. Taken an ambulance to the hospital? _____ <input type="checkbox"/> Refused	
c. Been hospitalized as an inpatient? _____ <input type="checkbox"/> Refused	
d. Used a crisis service, including sexual assault crisis, mental health crisis, family/intimate violence, distress centers and suicide prevention hotlines? _____ <input type="checkbox"/> 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? _____ <input type="checkbox"/> Refused	
f. Stayed one or more nights in a holding cell, jail, or prison, whether that was a short-term stay like a drunk tank, a longer stay for a more serious offence, or anything in between? _____ <input type="checkbox"/> Refused	
#4 = IF THE TOTAL NUMBER OF INTERACTIONS EQUALS 4 OR MORE: SCORE +1 FOR EMERGENCY SERVICE USE	
5. Have you been attacked or beaten up since you've become homeless? <input type="checkbox"/> YES <input type="checkbox"/> no <input type="checkbox"/> Refused	IF "YES" TO EITHER 5 OR 6: ADD +1 FOR RISK OF HARM
6. Have you threatened to or tried to harm yourself or anyone else in the last year? <input type="checkbox"/> YES <input type="checkbox"/> no <input type="checkbox"/> Refused	
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? <input type="checkbox"/> YES <input type="checkbox"/> no <input type="checkbox"/> Refused	IF "YES" to 7: ADD +1 FOR LEGAL ISSUES
8. Does anyone force you or trick you to do things that you do not want to do? <input type="checkbox"/> YES <input type="checkbox"/> no <input type="checkbox"/> Refused	IF "YES" TO EITHER 8 OR 9: ADD +1 FOR RISK OF EXPLOITATION
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? <input type="checkbox"/> YES <input type="checkbox"/> no <input type="checkbox"/> Refused	
B. 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? <input type="checkbox"/> YES <input type="checkbox"/> no <input type="checkbox"/> Refused	IF "YES" TO question 10 OR "NO" to question 11: ADD +1 FOR MONEY MANAGEMENT
11. Do you get any money from the government, a pension, an inheritance, working under the table, a regular job, or anything like that? <input type="checkbox"/> yes <input type="checkbox"/> NO <input type="checkbox"/> Refused	
12. Do you have planned activities, other than just surviving, that make you feel happy and fulfilled? <input type="checkbox"/> yes <input type="checkbox"/> NO <input type="checkbox"/> Refused	IF "NO" to 12: ADD +1 FOR MEANINGFUL DAILY ACTIVITY
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? <input type="checkbox"/> yes <input type="checkbox"/> NO <input type="checkbox"/> Refused	IF "NO" to 13: ADD +1 FOR SELF-CARE
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? <input type="checkbox"/> YES <input type="checkbox"/> no <input type="checkbox"/> Refused	IF "YES" to 14: ADD +1 FOR SOCIAL RELATIONSHIPS
C. WELLNESS	
15. Have you ever had to leave an apartment, shelter program, or other place you were staying because of your physical health? _____ <input type="checkbox"/> YES <input type="checkbox"/> no <input type="checkbox"/> Refused	
16. Do you have any chronic health issues with your liver, kidneys, stomach, lungs, or heart? _____ <input type="checkbox"/> YES <input type="checkbox"/> no <input type="checkbox"/> Refused	
17. If there was space available in a program that specifically assisted people who live with HIV or AIDS, would that be of interest to you? _____ <input type="checkbox"/> YES <input type="checkbox"/> no <input type="checkbox"/> Refused	
18. Do you have any physical disabilities that would limit the type of housing you could access, or would make it hard for you to live independently because you would need help? _____ <input type="checkbox"/> YES <input type="checkbox"/> no <input type="checkbox"/> Refused	
19. When you are sick or not feeling well, do you avoid getting help? _____ <input type="checkbox"/> YES <input type="checkbox"/> no <input type="checkbox"/> Refused	
20. Are you currently pregnant? (IF YES – due date: _____) _____ <input type="checkbox"/> YES <input type="checkbox"/> no <input type="checkbox"/> Refused	

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IF "YES" TO ANY OF THE ABOVE (15 - 20): SCORE +1 FOR PHYSICAL HEALTH	
21. Has drinking or drug use led you to being kicked out of an apartment or program where you were staying in the past? _____	<input type="checkbox"/> YES <input type="checkbox"/> no <input type="checkbox"/> Refused
22. Will drinking or drug use make it difficult for you to stay housed or afford your housing? _____	<input type="checkbox"/> YES <input type="checkbox"/> no <input type="checkbox"/> Refused
IF "YES" TO ANY OF THE ABOVE (21 - 22): SCORE +1 FOR SUBSTANCE USE	
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? _____	<input type="checkbox"/> YES <input type="checkbox"/> no <input type="checkbox"/> Refused
b. A past head injury? _____	<input type="checkbox"/> YES <input type="checkbox"/> no <input type="checkbox"/> Refused
c. A learning disability, developmental disability, or other impairment? _____	<input type="checkbox"/> YES <input type="checkbox"/> no <input type="checkbox"/> 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? _____	<input type="checkbox"/> YES <input type="checkbox"/> no <input type="checkbox"/> Refused
IF "YES" TO ANY OF THE ABOVE (23a, b, c AND/OR 24): SCORE +1 FOR MENTAL HEALTH	
IF THE RESPONDENT SCORED 1 FOR PHYSICAL HEALTH AND 1 FOR SUBSTANCE USE AND 1 FOR MENTAL HEALTH: SCORE +1 FOR TRI-MORBIDITY	
25. Are there any medications that a doctor said you should be taking that, for whatever reason, you are NOT taking? _____	<input type="checkbox"/> YES <input type="checkbox"/> no <input type="checkbox"/> Refused
26. Are there any medications, like painkillers, that you don't take the way the doctor prescribed or where you sell the medication? _____	<input type="checkbox"/> YES <input type="checkbox"/> no <input type="checkbox"/> Refused
27. Has your current period of homelessness been caused by an experience of emotional, physical, sexual, or other type of abuse, or by any other trauma you have experienced? _____	<input type="checkbox"/> YES <input type="checkbox"/> no <input type="checkbox"/> Refused
SCREENER SECTION (ALL of the items below MUST be completed for the Head of Household only)	
SCORING THE SCREENING	
VI-SPDAT INFORMATION	
Member of household is older than 65: IF YES ADD +1	/1
A. History of Housing & Homelessness (page 3 & 4: questions 1—3)	/2
B. Risks (pages 4: questions 4—9)	/4
C. Socialization & Daily Functions (page 4: questions 10—14)	/4
D. Wellness (pages 4 & 5: questions 15—27)	/6
LOCAL PRIORITIZATION FACTORS	
Member of household is 55 or older: IF YES ADD +2	/2
Head of household is between the ages of 16-24: IF YES ADD +2	/2
Household includes children under the age of 18: IF YES ADD +3	/3
Household includes someone who is a Veteran: IF YES ADD +3	/3
Domestic violence contributed to current homelessness: IF YES ADD +3	/3
History of eviction would make it challenging to get into housing: IF YES ADD +4	/4
TOTAL:	/34
Does the household meet the definition criteria for "Literally Homeless"? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the household meet the definition criteria for "Chronically Homeless"? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Proceed on next page

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Next Steps:

1. ALL household data MUST be entered in the Homeless Management Information System (HMIS) and the household enrolled in Coordinated Entry (CE) within 48 hours of completing the CE Screening.
2. If the household meets the criteria for “literally homeless” but does NOT meet the criteria for “chronically homeless, the household will be placed on the CE prioritization list for Rapid Re-Housing (RRH) projects. *This does not mean the household will enter an RRH project, just that they could be considered for one. Projects consider prioritization based on highest screening score, as well as their internal eligibility criteria. Households should be advised to continue exploring any and all resources and should be referred to resources outside of the CE system.*
3. If the household meets the criteria for “chronically homeless, the household will be placed on the CE prioritization list for Permanent Supportive Housing (PSH) projects. *This does not mean the household will enter a PSH project, just that they could be considered for one. Projects consider prioritization based on highest screening score, as well as their internal eligibility criteria. Households should be advised to continue exploring any and all resources and should be referred to resources outside of the CE system.*
4. If a household would be prioritized for a PSH project but does not require or want long-term rental assistance, they can choose to be placed on the prioritization list for RRH projects and should be referred to CE participating RRH projects.
5. Household could be considered for CE participating Transitional Housing projects depending on the project eligibility criteria.
6. If a household is either “literally homeless”, at risk of homelessness, recently homeless, or fleeing domestic violence, the separate CE Screening Tool for the Emergency Housing Vouchers (EHV) could also be completed and the household could be referred to the EHV project.

COORDINATED ENTRY ASSESSMENT (MUST be completed for the Head of Household only)

Date of CE Assessment (Screening): ____ / ____ / ____	Screener’s Name:	
Screening Location (agency/physical location):	Screening Type: <input type="checkbox"/> Phone <input type="checkbox"/> In Person	Screening Level: <input checked="" type="checkbox"/> Housing Needs Assessment
Prioritization Status: <input type="checkbox"/> Placed on prioritization list <input type="checkbox"/> Not placed on prioritization list		

COORDINATED ENTRY SCREENING RESULT/EVENT (MUST be completed for the Head of Household only)

Date of CE Screening Result/Event: ____ / ____ / ____	
Event:	
<input type="checkbox"/> Referral to Prevention Assistance project <input type="checkbox"/> Problem Solving/Diversion/Rapid Resolution intervention or service <input type="checkbox"/> Referral to scheduled CE Crisis Needs Assessment <input type="checkbox"/> Referral to scheduled CE Housing Needs Assessment <input type="checkbox"/> Referral to post-placement/follow-up case management <input type="checkbox"/> Referral to Street Outreach project or services <input type="checkbox"/> Referral to Housing Navigation project or services <input type="checkbox"/> Referral to Non-continuum services: Ineligible for continuum services <input type="checkbox"/> Referral to Non-continuum services: no availability in continuum services	<input type="checkbox"/> Referral to Emergency Shelter bed opening <input type="checkbox"/> Referral to Transitional Housing bed/unit opening <input type="checkbox"/> Referral to Joint TH/RRH project/unit/resource opening <input type="checkbox"/> Referral to RRH project resource opening <input type="checkbox"/> Referral to PSH project resource opening <input type="checkbox"/> Referral to Other PH project/unit/resource opening <input type="checkbox"/> Referral to Emergency Assistance/flex fund/furniture assistance <input type="checkbox"/> Referral to Emergency Housing Voucher <input type="checkbox"/> Referral to Housing Stability Voucher
If ‘Event’ was ‘Pr. Solving/div/Rap Res int or serv result’, was the client housed/re-housed in a safe alternative? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If ‘Event’ was ‘Ref to post-plac/follow-up CM result’, was the client enrolled in Aftercare project? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If ‘Event’ was a Referral to an ES, TH, Joint Th-RRH, RRH, PSH, or other PH, what is the name of the shelter or housing project?	
If CE Screening Result/Event answer was a Referral to an ES, TH, Joint TH-RRH, RRH, PSH, or Other PH opening, please answer the following:	
<ul style="list-style-type: none"> • Referral Result: <input type="checkbox"/> Successful: client accepted <input type="checkbox"/> Unsuccessful: client rejected <input type="checkbox"/> Unsuccessful: provider rejected • Date of Referral Result: ____ / ____ / ____ 	