Coordinated Entry EHV Screening Tool

Name (first middle last): | Date of Birth: | **Age:**

Alias/Other Names Used: | Social Security Number: _________-______-___________

Are you a veteran? ☐ Yes ☐ No ☐ Does not know ☐ Refused ☐Not collected | Screening Type: HUD | Client Location: CA-509

What is your race? *(check all that apply)*: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ White ☐ Unknown ☐ Refused ☐ Data not Collected

Are you: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Unknown ☐ Refused ☐ Data Not Collected

What is your gender: ☐ Male ☐ Female ☐ TG-MtF ☐ TG-FtM ☐ Gender Non-Conforming ☐ Refused ☐ Data Not Collected

Relationship to Head of Household: ☐ Self ☐ Spouse/partner ☐ Child ☐ Other family, specify: _________________________

Name of Head of Household *(if not Self)*:

1. PRIOR LIVING SITUATION – Where were you sleeping the night before you were screened for Coordinated Entry?

Homeless Situations:	☐ Place not meant for habitation ☐ Safe Haven	☐ Emergency shelter, including hotel/motel paid for with emergency shelter voucher
Institutional Situations:	☐ Foster care home or group home ☐ Hospital: non-psychiatric ☐ Jail, prison, juvenile detention	☐ Long-term care facility or nursing home ☐ Psychiatric hospital/facility ☐ Substance abuse treatment facility
Temporary/Permanent Situations:	☐ Residential project or halfway house w/o homeless criteria ☐ Hotel/motel paid for w/o emergency shelter voucher ☐ Transitional housing for homeless persons** ☐ Staying w/ family ☐ Staying w/ friends ☐ Rental by client, w/ GPD TIP subsidy ☐ Rental by client, w/ VASH subsidy	☐ Permanent housing for formerly homeless persons ☐ Rental by client, w/ RRH subsidy ☐ Rental by client, w/ HCV subsidy ☐ Rental by client, in public housing unit ☐ Rental by client, no ongoing subsidy ☐ Rental by client, w/ other subsidy ☐ Owned by client, no ongoing subsidy ☐ Owned by client, w/ ongoing subsidy
Other:	☐ Specify: _____________	☐ Does not know ☐ Refused

How many nights did you sleep in that location? #____________________

*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?* ☐ Yes ☐ 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. INCOME

Do you have income from any source? ☐ Yes ☐ No ☐ Does not Know ☐ Refused ☐ Data Not Collected

If YES, please indicate type/amount below:

☐ Alimony/Spousal Support $_________	☐ Pension/retirement from job $_______	☐ TANF $_________________________
☐ Child Support $___________________	☐ Private Disability Insurance $________	☐ Unemployment Ins. $______________
☐ Earned Income $_________________	☐ Retirement from Social Sec. $________	☐ VA Non-serv Pension $____________
☐ General Assistance $______________	☐ SSDI $____________________________	☐ VA Service Compen. $_____________
☐ Other $_________________________	☐ SSI $_____________________________	☐ Worker's Comp. $_______________

Total Monthly Income:

Do you receive non-cash benefits from any other source? ☐ Yes ☐ No ☐ Does not Know ☐ Refused ☐ Data Not Collected

If YES, please indicate type/amount below:

☐ Food Stamps $________________	☐ TANF Child Care Services $___________	☐ Other TANF-Funded Services $_______
☐ SSNP for WIC &________________	☐ TANF Transportation Services $_______	☐ Other Source $____________________

Coordinated Entry EHV Screening Tool

4. HEALTH INFORMATION

Do you have health insurance? ☐ Yes ☐ No ☐ Does Not Know ☐ Refused ☐ Data Not Collected

If YES, please indicate type:

☐ MEDICAID ☐ VA Medical Services ☐ State Health Insurance for Adults
☐ MEDICARE ☐ Employer Provided ☐ Indian Health Services Program
☐ State Children's HI Program ☐ Private Pay ☐ Other

Do you have a disabling condition: ☐ Yes ☐ No ☐ Unknown ☐ Refused ☐ Data Not Collected

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?
Alcohol Abuse	☐Yes ☐No ☐DNK ☐R ☐DNC	☐Yes ☐No ☐DNK ☐RFSD ☐DNC
Both Alcohol & Drug Abuse	☐Yes ☐No ☐DNK ☐R ☐DNC	☐Yes ☐No ☐DNK ☐ RFSD ☐DNC
Chronic Health Condition	☐Yes ☐No ☐DNK ☐R ☐DNC	☐Yes ☐No ☐DNK ☐ RFSD ☐DNC
Developmental Disability	☐Yes ☐No ☐DNK ☐R ☐DNC	☐Yes (if yes to disability, will always be yes here)
Drug Abuse	☐Yes ☐No ☐DNK ☐R ☐DNC	☐Yes ☐No ☐DNK ☐ RFSD ☐DNC
HIV/AIDS	☐Yes ☐No ☐DNK ☐R ☐DNC	☐Yes (if yes to disability, will always be yes here)
Mental Health Condition	☐Yes ☐No ☐DNK ☐R ☐DNC	☐Yes ☐No ☐DNK ☐ RFSD ☐DNC
Physical Disability	☐Yes ☐No ☐DNK ☐R ☐DNC	☐Yes ☐No ☐DNK ☐ RFSD ☐DNC

Have you ever experienced domestic violence? ☐ Yes ☐ No ☐ Refused

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

Are you currently fleeing from domestic violence? ☐ Yes ☐ No ☐ Refused

5. CURRENT LIVING SITUATION – Where are you sleeping right now/tonight?

Homeless Situations:	☐ Place not meant for habitation ☐ Safe Haven	☐ Emergency shelter, including hotel/motel paid for with emergency shelter voucher
Institutional Situations:	☐ Foster care home or group home ☐ Hospital: non-psychiatric ☐ Jail, prison, juvenile detention	☐ Long-term care facility or nursing home ☐ Psychiatric hospital/facility ☐ Substance abuse treatment facility
Temporary/Permanent Situations:	☐ Residential project or halfway house w/o homeless criteria ☐ Hotel/motel paid for w/o emergency shelter voucher ☐ Transitional housing for homeless persons** ☐ Staying w/ family ☐ Staying w/ friends ☐ Rental by client, w/ GPD TIP subsidy ☐ Rental by client, w/ VASH subsidy	☐ Permanent housing for formerly homeless persons ☐ Rental by client, w/ RRH subsidy ☐ Rental by client, w/ HCV subsidy ☐ Rental by client, in public housing unit ☐ Rental by client, no ongoing subsidy ☐ Rental by client, w/ other subsidy ☐ Owned by client, no ongoing subsidy ☐ Owned by client, w/ ongoing subsidy
Other:	☐ Specify: _____________	☐ Does not know ☐ Refused

Date you started staying at that location: ___ /___ /_____

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

Living Situation Verified By (CE Agency/Program):

Are you going to have to leave your current living situation within 14 days? ☐ Yes ☐ No ☐ Does not know ☐ Refused

If "Yes" answer the following questions:

Have you identified a permanent place to move to? ☐ Yes ☐ No ☐ Does not know ☐ Refused ☐ Data Not Collected

Do you have resources or support networks to obtain permanent housing? ☐ Yes ☐ No ☐ Does not know ☐ Refused

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 ☐ Does not know ☐ Refused ☐ Data Not Collected

Have you moved 2 or more times in the last 60 days? ☐ Yes ☐ No ☐ Does not know ☐ Refused ☐ Data Not Collected

Coordinated Entry EHV Screening Tool

6. OTHER

Phone Number: | Email:

Residence/Last Permanent Address:

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

If YES, how many? _____ Adults ______Children under 18

Is the household a family with children? ☐ Yes ☐ No | Is any member a Veteran or surviving spouse of a Veteran? ☐ Yes ☐ No

Does the client/household meet the definition criteria for “Literally Homeless”? ☐ Yes ☐ No

Is the client/household at risk of homelessness? ☐ Yes ☐ No | Was the client/household recently homeless? ☐ Yes ☐ No

Is any member of the household age 55 or older? ☐ 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
Cancer
Chronic kidney disease
Chronic lung diseases or moderate to severe asthma
Dementia or Alzheimer’s
Diabetes
Down syndrome
Serious heart conditions
HIV/AIDS
Liver disease
Severe obesity (BMI of 40+)
Pregnancy
Sickle cell disease or hemoglobin disorders
Smoking, current or former
Solid organ or blood stem cell transplant
Stroke or cerebrovascular disease
Substance use disorders

Screener Section *(the items below MUST be completed)*

*Clients/households NEED to meet at least **ONE** of the following to be referred to the EHV project: **1) Literally Homeless; 2) At risk of homelessness; 3) Recently homeless; 4) Fleeing domestic violence***

If the client/household DOES NOT meet at least ONE of those four eligibility criteria, do not enroll them in Coordinated Entry or complete the Coordinated Entry EHV Screening on HMIS.

Coordinated Entry Assessment

Date of CE Assessment (Screening): ____ / ____ / _______ | **Screener’s Name:**

Screening Type: ☐ Phone ☐ In Person | **Screening Location *(agency/physical location):***

Prioritization Status: ☐ Placed on prioritization list (N/A for EHV screening)
☒ Not placed on prioritization list *(EHV screenings are not placed on the CE By-Name List)*

Coordinated Entry Screening Result/Event

Date of CE Screening Result/Event *(date referral is sent to EHV provider))*: ___ / ___ / _____

CE EHV Screening Result:

☐ Referral to Prevention Assistance project (homelessness assistance)
☐ Problem Solving/Diversion/Rapid Resolution intervention or service
☐ Referral to scheduled CE Crisis Needs Assessment
☐ Referral to scheduled CE Housing Needs Assessment
☐ Referral to post-placement/follow-up case management
☐ Referral to Street Outreach project or services
☐ Referral to Housing Navigation project or services
☐ Referral to Non-continuum services: Ineligible for continuum services
☐ Referral to Non-continuum services: no availability in continuum services
☐ Referral to Emergency Shelter bed opening
☐ Referral to Transitional Housing bed/unit opening
☐ Referral to Joint TH/RRH project/unit/resource opening
☐ Referral to RRH project resource opening
☐ Referral to PSH project resource opening
☒ Referral to Other PH project/unit/resource opening

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:

- Referral Result: ☐ Successful: client accepted ☐ Unsuccessful: client rejected ☐ Unsuccessful: provider rejected
- Date of Referral Result: ____ / ____ / _______