

Intake

- Engages potential users of services
- Screens potential users of services
- Determines eligibility
- Gathers pertinent information
- Is the first phase of case management
- Can be incorporated into the assessment phase

Intake Practices

- Does not need to be a long process
- Should allow case managers to smoothly transition to the assessment phase
- Opportunity to explain services and expectations
- Develops the relationship with the organization
- Create a user friendly form
- Collect data and information (HMIS) to reduce having to repeat questions in other phases

Triage Assessment

Name: _____

Name of staff person completing form: _____

Check one: Individual Family Date _____ Time _____

SECTION A: Basic Information

This information should be collected (in person or by phone) for each member of a presenting household, with the head-of-household listed on the first line.

1) Name (First Name, Middle Initial, Last Name)

2) Date of Birth _____ 3) Gender _____ 4) Social Security # _____

5) City of Birth _____ 6) State of Birth _____

7) County of Birth _____

8) Additional family/household members:

Name: _____ DOB: _____ Gender: _____ SS# _____

Name: _____ DOB: _____ Gender: _____ SS# _____

Name: _____ DOB: _____ Gender: _____ SS# _____

Name: _____ DOB: _____ Gender: _____ SS# _____

Name: _____ DOB: _____ Gender: _____ SS# _____

Name: _____ DOB: _____ Gender: _____ SS# _____

9) Check all that apply:

- American Indian Native Hawaiian / Other Pacific Islander
- Asian White
- Black or African American Other

10) Check applicable response:

- Hispanic
- Non-Hispanic

11) Primary language: _____

12) Secondary languages: _____

13) Proficient in English? No Yes

14) Veteran? No Yes... Discharge Date _____

15) Level of education:

GED

Last grade completed: _____

Some college

College degree

Masters degree

Technical training – indicate field:

16) Contact info for household:

Mailing address:

Phone number(s):

17) Emergency contact:

Name:

Address:

Phone number:

18) Person has stayed in shelter in Dayton/Montgomery County before.

No

Yes ... When and where? *(Verify and pull dates from HMIS and TOP Members Web)*

19) Referral source:

SECTION B1: Diversion

20) Where did you sleep last night? (Get **specific** info such as **street address, name of shelter or hospital, etc.**)

- Non-housing: _____
- Emergency shelter: _____
- Transitional housing for homeless persons: _____
- Psychiatric facility: _____
- Substance abuse treatment facility: _____
- Hospital: _____
- Jail/prison: _____
- Domestic violence situation: _____
- Living with relative/friend: _____
- Rental housing: _____
- Own apartment or house: _____
- Hotel or motel: _____
- Foster care: _____
- Other: _____

21) Where have you slept in the last 30 days? (Check all that apply. Get **specific** info such as **street address, name of shelter or hospital, etc.**)

- Non-housing: _____
- Emergency shelter: _____
- Transitional housing for homeless persons: _____
- Psychiatric facility: _____
- Substance abuse treatment facility: _____
- Hospital: _____
- Jail/prison: _____
- Domestic violence situation: _____
- Living with relative/friend: _____
- Rental housing: _____
- Own apartment or house: _____
- Hotel or motel: _____
- Foster care: _____
- Other: _____

22) Why did you leave your **last** housing situation? (Check all that apply.)

- Rent problems
- Went to prison or jail... For what? _____
- Evicted for a reason other than rent problems
- Conflict with family or friends
- Went into the hospital... For what? _____
- Overcrowding
- Domestic violence
- Fire
- Housing condemned
- Other: _____

23) Are you in danger of someone physically hurting you or any member of your household right now?

- No
- Yes... Can you tell me more about this? (If any indication of DV, contact DV hotline for an assessment.) Obtain potential abuser's name and a physical description so that security can be alerted and a safety plan can be put in place.

24) Provide housing and/or shelter history for the last three years:

Location	Approx. Dates	Lease Holder?	If no, provide name of -- and relationship to -- primary tenant

25) Zip code of last permanent residence: _____

26) A. Identify family in the area. Get name, address and phone number.

Name: _____
Address: _____
Phone Number: _____

B. Identify friends in the area. Get name, address and phone number.

Name: _____

Address: _____

Phone Number: _____

27) Can you safely sleep where you slept last night again tonight? No Yes

28) If not, describe why: _____

Can you stay with family or friends tonight while we work with you to obtain a place to stay?

Can you or I contact someone to see if this is possible? No Yes _____

29) How much was your income in the last 30 days? \$ _____

30) Amount of money in...

Checking account \$ _____ Does not have a checking account

Savings account \$ _____ Does not have a savings account

31) What is your current source of income? (Check all that apply.)

Full or part-time work – Employer: _____

Hourly wage: \$ _____ Hours per week: _____

Day labor SSI (for what/whom?) _____

Unemployment SSDI (for what/whom?) _____

TANF (welfare) Short-term disability

Social Security Child support Other: _____

Veterans benefits Scrap/recycling _____

32) Do you have a Payee? No Yes If yes, Who? _____

33) Do you receive food stamps? No Yes... Amount: _____

34) Do you have medical coverage? No Yes... What kind? _____

35) Person could be housed tonight if provided with the following service(s):

Transportation Food Mediation services

Furniture Help with utilities or rent Other: _____



**If YES to question 35, complete the Homeless Diversion Form.
If NO to question 35, skip to page 7.**

SECTION B2: Homeless Diversion Form

To be completed if a location has been identified for diversion

36) Location where person(s) will be sleeping tonight: _____

37) Relationship to person: _____

38) Contact information: _____

39) Length of time person(s) may remain at this location: _____

40) Reason person(s) cannot stay longer: _____

Please answer the following questions about the diversion location:

41) Illegal activities are taking place at the location.
(e.g. prostitution, drug activities) No Yes

42) Someone is living there who has abused the person or any
member of the household in the present or past. No Yes

43) There is a vacate order. No Yes

44) The property is condemned. No Yes

45) There are unsafe physical conditions. No Yes

46) The person is fearful to go to the location. No Yes

Describe reason: _____

**IMPORTANT: If "YES" to any of questions 41-46,
a new diversion location is needed or person is placed in shelter.**



*****If client is diverted, skip to Triage Assessment Summary on page 12.*****

SECTION C: Risk Assessment

To be completed if no diversion location has been identified

47) Do you have any medical needs right now?

No Yes...Explain: _____

48) Are you in need of medical care or in pain?

No Yes...Explain: _____

49) Which of the following describe the medical condition of the person(s)? *(Check all that apply.)*

	<u>Length of condition</u>	<u>How does condition affect ability to function independently?</u>
<input type="checkbox"/> Wheelchair	_____	_____
<input type="checkbox"/> Pregnant	_____	_____
<input type="checkbox"/> TB	_____	_____
<input type="checkbox"/> Open wounds	_____	_____
<input type="checkbox"/> HIV	_____	_____
<input type="checkbox"/> Asthma	_____	_____
<input type="checkbox"/> Hypertension	_____	_____
<input type="checkbox"/> Heart disease	_____	_____
<input type="checkbox"/> Hepatitis	_____	_____
<input type="checkbox"/> Diabetes	_____	_____
<input type="checkbox"/> Morbidly obese	_____	_____
<input type="checkbox"/> Vision impaired	_____	_____
<input type="checkbox"/> Hearing impaired	_____	_____
<input type="checkbox"/> Limited mobility	_____	_____
<input type="checkbox"/> Other: _____	_____	_____

50) Are you currently using drugs or alcohol? No Yes

If yes, which drugs? _____

How often do you use? _____

When did you last use? _____

51) Have you used drugs or alcohol in the past? No Yes

If yes, which drugs? _____

52) If we drug tested you today, would you be clean? No Yes

53) Person has had the following from using drugs/alcohol: *(Check all that apply.)*

- Overdose
- Blackouts
- Shakes
- Seizures

54) Do you consider yourself to be in recovery from an addiction to drugs or alcohol?
 No
 Yes... How long have you been in recovery? *(Will need to provide supporting documentation.)*

55) Have you ever participated in a drug or alcohol treatment program? No Yes
 If yes, when and where? _____

56) Is person currently doing Outpatient Treatment for AOD? No Yes*
**If YES, complete DOORS enrollment form and bill under DOORS.*

57) Is person going to pre-admission groups for in-patient treatment? No Yes*
**If YES, complete DOORS enrollment form and bill under DOORS.*

58) Have you been hospitalized for mental illness?
 No
 Yes... WHAT mental illness, how many times, where and for how long?

59) Have you ever been diagnosed with a mental illness?
 No
 Yes... WHAT mental illness, who diagnosed you, and when?

60) Have you ever been on medication for mental health issues?
 No
 Yes... What meds, and when? _____

61) Is person currently linked with a CMHC? No Yes*
**If YES, complete DOORS enrollment form and bill under DOORS.*

62) Has person in the last 30 days gone to CC for an AOD or Mental Health Assessment?
 No Yes*
**If YES, complete DOORS enrollment form and bill under DOORS.*

63) Have you ever been linked with an MRDD provider? No Yes

64) Were you enrolled in special classes during school? No Yes

65) If taking ANY prescription medication, answer for each medication. Be sure to ask whether the person physically has the medication with him/her now.

PERSON PRESCRIBED	DRUG	DOSE	FREQUENCY	HAVE NOW

66) Person knows why he/she is taking these meds. No Yes NA

67) Person has side effects from the meds. No Yes NA

If yes, describe: _____

68) Person has taken medications as prescribed. (Doesn't need prompting.) No Yes

69) Name and contact information for all that apply:

Primary care provider (*past or present*)

Name: _____

Contact info: _____

Mental health provider (*past and/or present*)

Name: _____

Contact info: _____

Substance abuse counselor/treatment provider (*past and/or present*)

Name: _____

Contact info: _____

70) Do you want to hurt yourself or anyone else right now?

No

Yes... If yes, assessment staff evaluates if person has concrete plan and the means and refers for emergency psychiatric treatment as needed.

71) Drugs and weapons are not allowed in this facility. If you have either in your possession right now, I will give you an opportunity to leave and come back without them. If you are found with drugs or weapons in the shelter, there are consequences. (*Explain consequences.*)

72) Check all that apply:

	<u>Currently Experiences</u>	<u>History of</u>	<u>N/A</u>	<u>What, when, where, how?</u>
Homicidal ideas/attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Assaultive behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Severe depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Severe thought disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cognitive impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Suicidal ideas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Suicidal attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arson/fire setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Victim of sexual abuse/assault	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Victim of trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

SECTION D: Tuberculosis Screen

To be completed ONLY if person is entering gateway shelter.

- 81) Have you been coughing for more than 3 weeks? No Yes
- 82) Have you recently coughed up blood or sputum?
(In the last 3 months) No Yes
- 83) Have you had recent, unintentional and continuous weight loss of 5 pounds or more? No Yes
- 84) Have you had a recurrent fever of more than 100° F in the last month? No Yes
- 85) Have you had unusual sweating, especially at night? No Yes
- 86) Have you had ongoing, unexplained fatigue or weakness? No Yes
- 87) Have you ever had a positive TB skin test? No Yes

⇒ If yes to 81 and one of 82-86, person should be tested. If yes to 87, person should be tested.

SECTION E: Triage Assessment Summary Form

To be completed for EVERY applicant; documents outcome of the application.

Please check the appropriate box:

- Person(s) diverted (outside of homeless providers).**

Address: _____

Relationship to person(s): _____

Length of time person(s) permitted to stay: _____

Additional information: _____

- Person(s) diverted to program shelter:** _____

- Person(s) referred to hospital.**

Name of hospital: _____

Anticipated discharge date: _____

If applicable, include information on the placement of dependent family members: _____

- Person(s) unable to be placed in shelter because of violent or otherwise dangerous behavior.**

Please describe person's specific actions and actions taken by staff: _____

If applicable, include information on the placement of dependent family members: _____

- Person is a danger to himself/herself or others and was referred for emergency psychiatric care.**

Referred to: _____

Anticipated discharge date: _____

If applicable, include information on the placement of dependent family members: _____

- Person(s) placed in gateway shelter.**

Assessment

- Information gathering phase
- Sufficient information needs to be collected to make decisions
- Assessment is collaborative (between client and case manager)
- Actively involves the client
- Requires skill and knowledge
- Core of case management
- Training is needed to be successful in the assessment process
- Cannot be the same process for everyone, needs to be client focused and system oriented
- A good assessment is the basis of an effective service plan

Housing Opportunities Assessment FOR INDIVIDUALS

Name: _____

Name of staff person completing form: _____

Date _____ Time _____

SECTION A: Income/Employment/Resources

1. What is your current source of income? (Check all that apply)

Full or Part Time Work: Employer: _____ Hourly Wage: _____
Hours per week: _____

Day Labor: Employer: _____ Hourly Wage: _____
Days per Week: _____

SSI/SSDI How much? _____ For what? _____
For whom? _____

VA Benefits For what? _____ How much? _____

Unemployment How much? _____ How much left? _____

Scraping How much? _____

2. Person has a Representative payee. No Yes

If yes: Name: _____

Relationship: _____ Contact Number: _____

3. Does the person have any applications pending (or receives – how much?) with one of the following?

Food Stamps _____

VA Benefits _____

SSI/SSDI _____

Medicaid/Medicare _____

Disability Assistance from the Job Center _____

4. If person is not working, describe situation. (Person is unable to work, seeking employment, etc.)

5. Check all applicable applicant strengths:

- Speaks English.
- Has recent work history.
- Reads/writes in English.
- Has steady work history.
- Can do basic math.
- Has employment references.
- Is eligible to work in U.S.
- Computer literate.
- Skilled trade. (*Describe*): _____

6. Person has outstanding debt. No Yes...If yes, describe type and amount of each:

7. Does anyone in the HH owe any back money to utility companies? No Yes

Please list the company and estimated amount: _____

8. Does anyone in the HH pay or owe back child support? No Yes

Please explain: _____

9. Person is involved in gambling. No Yes

If yes, please explain:

10. Person has a driver's license. No Yes

11. Person has a car. No Yes

12. Person has a case manager or counselor from a community-based service agency?

No Yes If yes, list name, agency and contact information:

SECTION B: Housing and Homeless History

13. Five year housing history: *(Collect the following information on each location.)*

Address	Lease in client's name?	Relationship to primary tenant	Approx. dates	Reason for leaving	Amount of rent or mortgage	Unpaid rent arrears and amounts

14. History of evictions. No Yes

Include # of times and dates

15. Has person been evicted from DMHA or other subsidized housing?

If yes: Where? _____

When? _____

For what? _____

16. Client has lived in DMHA or other subsidized housing? No Yes...

When: _____

Where: _____

Length of stay: _____

Reason for leaving: _____

Client is in arrears. No Yes...Amount owed to DMHA: _____ *(Need supporting documentation.)*

17. Application for Section 8 or Public Housing pending. No Yes

18. Lifetime homeless history: For each episode, indicate if sheltered, doubled-up or unsheltered. For last five (5) years, also indicate length of time homeless for each episode.

SECTION C: Housing Preferences

19. Prefers to live in the following neighborhoods:

20. Prefers to NOT live in the following neighborhoods:

21. Would consider sharing an apartment. No Yes

22. Believes he/she can afford \$ _____ per month in rent.

23. Interested in or is considering: *(check all that apply)*

- Transitional housing
- Congregate permanent supportive housing
- Scattered site permanent supportive housing
- DMHA or other subsidized housing
- FMR (Fair Market Rent)

24. Household size: _____ Needed number of bedrooms: _____

25. Household requires a handicapped-accessible living situation. No Yes

26. Other needs/preferences regarding housing. No Yes
If yes, describe:

SECTION D: Physical Health

27. List and describe any medical conditions and impact on person's ability to function independently.

28. List and describe any medical hospitalizations in the last 3 years. (*Obtain copy of medical records.*)

29. Medical condition(s) interfere with person's ability to obtain/maintain housing. No Yes

30. Date of last physical: _____

SECTION E: Mental Health/MR/DD

31. Have you ever been hospitalized for mental illness? No Yes
If yes, WHAT mental illness? _____ When? _____
Where? _____ How long in the hospital? _____
How many times have you been hospitalized? _____

32. Have you ever been diagnosed with a mental illness? No Yes
If yes, WHAT mental illness? _____ When? _____
Who diagnosed you? _____

33. Have you ever been on medication for a mental illness No Yes
What medication? _____ When? _____
For what? _____
Why did you stop taking it? _____
Are you currently on it? _____

34. Are you linked with a CMHC? No Yes
What agency? _____ CM's name: _____

35. MR/DD issues interfere with person's ability to obtain/maintain housing. No Yes

36. Mental health issues/mental illness interfere with person's ability to obtain/maintain housing. No Yes

37. If taking ANY prescription medication, answer for each medication. Be sure to ask whether the person physically has the medication with him/her now.

Drug	Person Prescribed	Dosage	Frequency	Have now?

38. Do you know why you're taking these meds? No Yes

39. Do you have side effects? No Yes
 What side effects? _____

SECTION F: Substance Abuse

40. Person has been in detox. No Yes
 If yes, list number of times, when, where and for how long.

41. Do you consider yourself to be in recovery from drugs and alcohol? No Yes
 If yes, how long? _____
 If in recovery, what is person doing to stay clean and sober? _____

42. Have you ever participated in a drug or alcohol treatment program? No Yes
 If yes, when? _____ where? _____

43. Are you currently doing outpatient treatment? No Yes
 Where? _____ How long have you been? _____

44. Have you used drugs or alcohol in the past? No Yes
 If yes, which ones? _____
 Length of clean time? _____

45. If we tested you today, would you be clean? No Yes

46. Have you ever had the following from drugs and alcohol?
 Overdose Black Outs Shakes Seizures
47. Drugs or alcohol interfere with person's ability to maintain housing. No Yes

SECTION G: HUD Qualified Disability

48. Is there at least one adult in the household who has a documented disabling condition?
 No Yes
49. Is it expected to be of long-continued and indefinite duration? No Yes
50. Does this disability substantially impede his or her ability to live independently? No Yes
51. Does the client have a documented AOD? No Yes
52. Does the documented AOD impede his or her ability to live independently? No Yes

SECTION H: Legal

53. Person has been in jail or prison. No Yes
 What year? _____ and for how long? _____
 For what? _____
54. Is person a registered sex offender? No Yes
55. Has person ever been convicted of drug manufacturing or drug trafficking? No Yes
56. Has person ever been convicted of an arson charge? No Yes
57. Person has pending charges against him/her.
 No Yes...Please explain: _____
(Need supporting documentation.)
58. Person has pending court dates. No Yes : _____
59. Person is on: probation parole *(Need supporting documentation.)*
 Name and contact information for probation/parole officer: _____
 Name and contact information of lawyer: _____

SECTION I: Current Supports

60. Explore the person's current support systems. (E.g. family support and involvement, religious affiliations/spiritual activities, partner or spouse, support groups, friends, 12-step group, 12-step sponsor, community involvement, counselor, etc.) For each, describe the nature of the support, including names, frequency of contact, etc.

Scoring Sheet for Housing Opportunities Assessment (FOR HOMELESS INDIVIDUALS)

Indicator:	Score	Client's
1. Is client's HH income at or below 35% of the median income for the county? (See FMR Table)	YES/NO	
2. Is household income in current month at least \$800 a month?	YES/NO	
3. Is client willing to go to Residential AOD treatment?	YES/NO	
4. Is client willing and able to work a job?	YES/NO	
5. Is client interested in going to school full time?	YES/NO	
6. Is client an honorably discharged veteran?	YES/NO	
7. Is client over the age of 55?	YES/NO	
8. Is the client between the ages of 18-21?	YES/NO	
9. Is the client SPMI? (diagnosis, assessment SSI documentation)	YES/NO	
10. Is the client chronically homeless? (shelter stay history, self declaration, outreach worker documentation)	YES/NO	
11. Does client have the means to maintain rent, or is willing and able to obtain and or increase employment?	YES/NO	
12. Has client been employed for at least 6 of the last 12 months? If no, 20 points.	20 pts	
13. Has the client been employed for at least 3 of the past 5 years (and not received benefits)? If no, 20 points.	20 pts	
14. Can client get utilities in their name? If no, 10 points.	10 pts	
15. Can client furnish an apartment? If no, 10 points.	10 pts	
16. Can client secure two landlord recommendations? If no, 10 points.	10 pts	
17. Does client have a history (more than 1) of evictions in the last 5 years? If yes, 10 points.	10 pts	
18. Does the client have substance abuse or mental health issues? If presently experiencing, 20 points. If client is not presently experiencing, but has history of AOD or MH issues 10 points.	20 pts/10 pts	
19. Does the client have a GED? If no, 10 points.	10 pts	
20. Does client have a criminal history (felony conviction within 10 years or sex offender)? If yes, 20 points.	20 pts	
Total	130	
21. Is there a documented disabling condition? (diagnosis, SSI documentation, assessment)	YES/NO	
22. Is this disabling condition to be of long-continued and indefinite duration? (history, SSI documentation)	YES/NO	
23. Does the client have documented AOD? (assessment by licensed professional)	YES/NO	
24. Does this disability (in question 21 or 23) affect the client's ability to live independently? (PSH DLA ≥4)	YES/NO	

If yes to question 2, and client scores a 50 or less = Fair Market Rent

If yes to question 3, and client is willing = Residential AOD Treatment

If yes to 4 or 5 and scores between a 50 and 80 = Transitional Housing (see TH scoring sheet)

If yes to question 6 = VA per Diem

If yes to question 7 = Senior Housing

If yes to question 8 = Daybreak

If yes to question 11 = Rapid Re Housing

If yes to question 21 **and** 22, and a yes to 24 (proven by an average of 4 or above on the DLA) and scores between a 80 and 130 = Permanent Supportive Housing (referral determined by type of needed services, ex: Iowa, Ohio Commons, MVHO Shelter Plus Care, Eastway Housing)

If yes to question 10 **and** 23 and a yes to 24 (proven by an average of 4 or above on the DLA) and scores between a 80 and 130 = Permanent Supportive Housing (referral determined by type of needed services, ex: Iowa, Ohio Commons, MVHO Shelter Plus Care)

If client answers yes to question 9 (client is SPMI) and yes to question 10= Housing First.

Describe in greater detail the housing needs, requirements of applicant(s), and other relevant information. (*e.g. number of bedrooms, handicapped-accessible, etc.*)

Describe any other relevant information related to housing placement options.

What are the recommendations of the supervisor (specific housing location)?

Signature of Case Manager _____ Date: _____

Signature of Supervisor _____ Date: _____

Transitional Housing Score Sheet

Is the client male? No Yes

If yes, is the client currently enrolled in school? No Yes

If yes = De Paul Center

Is the client focused on finding/maintaining employment? No Yes

If yes = Booth House

Is the client female? No Yes

If yes = make referral to WIN

If yes, does the client have a recent criminal history? No Yes

If yes = Mercy Manor

If yes, does the client have issues with PTSD and want to participate in a program? No Yes

If yes = Linda Vista

Checklist of Documentation Collected:

Entitlements/Income verification

Food stamps Veteran benefits

SSI Medicaid

SSDI Medicare

TANF

Completed housing applications : (Check all applicable) PSH Section 8 DMHA

Birth certificates

Social security card(s) *[if applicable]*

Driver's license/State ID *[if applicable]*

Goal Planning

- Training is needed to be successful in goal planning
- Cannot be the same for everyone
- Fundamental to the case management process
- Specific goals broken down to incremental behaviors to accomplish goals
- Goals must be positive, client focused, realistic, understandable, achievable and measurable
- Must not be seen as a success/failure process
- Tied to outcomes
- Flexible
- Can be seen as a contract between the case manager and the client
- Must establish timeframes, priorities, and allocate responsibility
- Don't confuse case managers goals with client goals