

Western Continuum Pre-Screening Assessment

(For DVAC USE ONLY)

The Pre-Screening Assessment for the Western Continuum uses these questions to help determine the client's initial needs and whether the Coordinated Assessment Tool step of the process should be performed or the client should be sent for other out of CE services.

For all new clients, please complete the pre-screening below. See CoC Policy for determining whether a returning client should be screened.

Screening Date:

Interviewer:

DVAC Identifier:

Are you literally homeless? Yes

No

Are you at risk for becoming homeless? Yes

No

Is anyone in your home making you feel unsafe or afraid? Yes

No

Fair Housing Questions

Do you believe you were discriminated against in an eviction process based on your race, color, national origin, religion, sex, familial status or disability? Yes

No Unknown

If yes, would you like a request to be sent to the Fair Housing Law Center to receive professional legal advice? Yes

In your search for housing, do you feel that you have been discriminated against based on your race, color, national origin, religion, sex, familial status or disability? Yes

No Unknown

If yes, please direct the consumer directly to the fair housing website at <http://fhlaw.org/request-services> to complete the referral process.

Homeless Assessment

Is this the first time you have been literally homeless, which means living in a shelter, car, or other location not intended for sleeping?

Yes No

Place not meant for human habitation
Emergency Shtler
Safe Haven
Interim Housing
Transitional Housing

Where did you sleep last night?

Homeless Episode History – (No more than 3 years of history) – Please record all homeless episodes for the client/household into the grid below by entering the homeless episode location, along with location name and start and end dates for each occurrence in a new row. If client is currently staying in the location, enter today’s date as the End Date.

Where did you sleep?*	Start Date	End Date	Leave Reason
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Current continuous days homeless:

Do you have a Disabling Condition: Yes No

Has the condition been verified by a medical doctor or licenses practitioner: Yes No

REMINDER: If Yes, Give “Verification of Disability Form” to be completed.

Been literally homeless for at least the last 12 continuous months: Yes No

Had four or more separate episodes of literal homelessness within the past three years that total at least 12 months: Yes No

Current Housing Status:

Homeless
At imminent risk of losing housing
Homeless only under other fed. statutes
Fleeing domestic violence
At-risk of homelessness
Client doesn't know
Client refused

Chronically Homeless: Yes No

Would you be willing move to another community within Western Pennsylvania if housing options were available: Yes No

If you are willing to relocate, which counties in the Western Continuum of Care would you consider?

Armstrong County

Butler County

Cameron County

Clarion County

Clearfield County

Crawford County

Elk County

Fayette County

Forest County

Greene County

Indiana County

Jefferson County

Lawrence County

McKean County

Mercer County

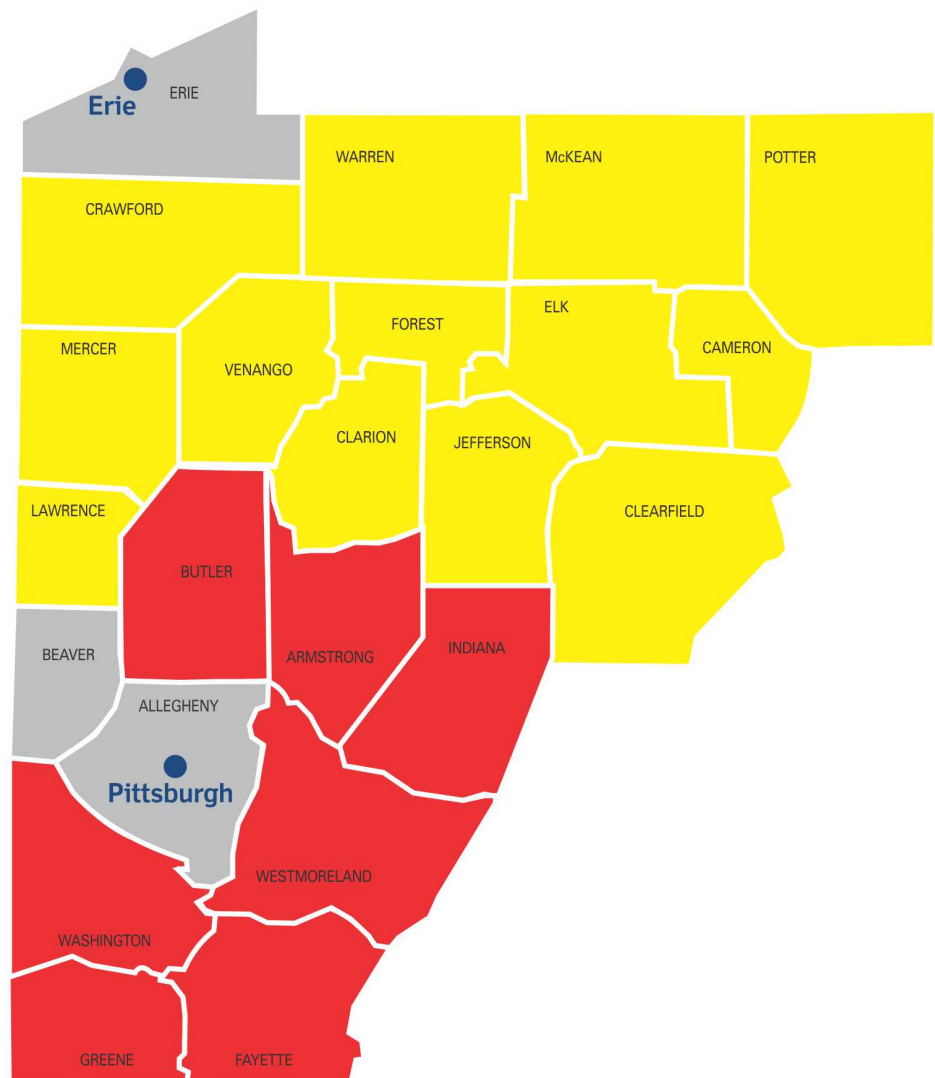
Potter County

Venango County

Warren County

Washington County

Westmoreland County



Health and Safety

Physical Health Section

Excellent
Very Good
Good
Fair
Poor
Client doesn't know
Client refused

How is your general overall physical health:

Do you have health insurance: Yes No

Are you pregnant: Yes No

 If so, what is your Due Date:

Do you have any current/immediate health concerns: Yes No

Are you able and/or willing to receive care: Yes No

Have you been on, are you currently on, or are you
in need of medication for any physical health issue: Yes No

Is the medication a life sustaining medication: Yes No

Are there medications that you are supposed
to be taking, which you are not taking, because
you cannot afford them, you do not have
health insurance, they have been stolen,
or you sold them to make money: Yes No

Do you have any of the following health diagnosis?

 Kidney disease/Renal disease/Dialysis: Cancer/Chemotherapy/Radiation:

 Heart Disease/Arrhythmia/Irregular Heart Beat/Congestive Heart Failure:

 Emphysema/COPD:

 Asthma:

 HIV/AIDS:

 If Yes, Are you seeking services related to HIV/AIDS: Yes No

 Frostbite/Hypothermia:

 Heat Stroke/Heat Exhaustion:

 Liver Disease/Cirrhosis/Hepatitis C/Interferon Treatment:

 Diabetes: Tuberculosis:

Have you been hospitalized as an inpatient
in the past 3 months due to any of the
conditions listed above: Yes No

Do you or someone in your household need
housing that has handicap accommodations: Yes No

 If so, describe Needs:

Mental Health Section

Excellent
Very Good
Good
Fair
Poor
Client doesn't know
Client refused

How is your general overall mental health:

Are there medications that you are supposed to be taking, which you are not taking, because you cannot afford them, you do not have health insurance, they have been stolen, or you sold them to make money:

Yes No

In the past 3 months, have you:

Been in an in-patient mental health facility/Self-Admit (201 voluntary committal):

Used a mental health crisis service: Attempted suicide:

Been admitted to the hospital against your will (302 involuntary committal):

Been the victim of a violent attack:

Had a serious brain injury that required treatment: Suffered a loss/ death of a family member:

Been in mental health treatment:

Lacked resources to bathe, do laundry, self-care:

Had increased anxiety:

Felt Hopeless/Helpless:

Are you currently, have you ever been, or are you eligible for Assertive Community Treatment (ACT) or Community Treatment Teams (CTT) or other comparable services:

Yes No

Substance Abuse Section

Do you have a history of substance abuse:

If Yes, when did you last use:

What substance did you abuse:

Are you currently/recently in treatment: Yes No

Are you currently prescribed Methadone/
Suboxone/Vivitrol: Yes No

Which one are you currentl prescribed: Methadone Suobxone Vivitrol

Substance Abuse History Comments:

Is your current usage affecting your ability
to maintain housing: Yes No

In the past 3 months, have you:

Overdosed on drugs:

Had an alcoholic seizure:

Been revived by Narcon/Naloxone:

Consumed alcohol every day for the past month:

Abused prescribed medication or illegal drugs:

Been treated for drug/alcohol abuse:

Blacked out due to use:

Had memory loss or inability to focus due to use:

Been disoriented to date, time and place due to use:

Are you interested in a program that provides
substance abuse services or addiction treatment
services? Yes No

Are you looking for a group setting where others
around you will be sober and the program encourages
complete sobriety: Yes No

Reminder: If consumer acknowledged substance abuse issues, they should be referred for transitional housing – substance abuse. Discuss this option and what it offers.

Domestic Violence

Domestic Violence Survivor:

When Situation Occured:

Are you fleeing or attempting to flee violence from an intimate partner, immediate household member, or family member?

Yes

No

Veteran Status

Were you ever on active duty or are you still in the Armed Forces in the United States:

Yes

No

Date entered military service (year):

Date separated from military service (year):

Did you serve in a combat zone:

Yes

No

Branch of the Military:

Discharge Status:

Do you have a military ID:

Yes

No

If Yes, select ID Type(s):

Military Card ID

DD-2014

Have you applied for or have a pending application for VA benefits or compensation:

Yes

No

Are you eligible for benefits or compensation but have not applied:

Yes

No

VA Benefit Comments:

Income and Benefits

Are you employed: Yes No Client Refused

Employment Status

Number of hours a week:

OR-

Reason Not Employed:

Type of Income:

Earned Income (i.e. employment income)

Unemployment Insurance

Supplemental Security Income (SSI)

Social Security Disability Insurance (SSDI)

Veteran's Disability Payment

Private Disability Insurance

Worker's Compensation

Temporary Assistance for Needy Families (TANF)

General Assistance

Retirement Income from Social Security

Veteran's Pension

Other Pension

Alimony or other spousal support

Other Income

Total Household Gross Monthly Income:

Are you eligible for non-cash or cash benefits but have not applied. Yes No

Do you receive any of the following non-cash benefits:

Supplemental Nutrition Assistance Program (SNAP) (Food Stamps)

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

TANF Child Care Services

TANF Transportation Services

Other TANF-funded Services

Other Source

Income Verified: Yes No

Household

Family Type:

Youth Head of Household: Yes No

Number of People in the Household:

If housing is needed - Minimum number of bedrooms required:

Have you or your family, in the past 3 months:

Had any children separated from the family due to inability to maintain housing:

Had any school-aged children who were not enrolled in school or missing school due to housing issues:

Check any of the following that apply:

Current Child Protective Services Case:

Single parent with 2+ children AND any children under 11 AND pregnant head of household:

Two parents with 3+ children AND any child 6 or younger AND pregnant head of household:

Criminal Background

Do you have a criminal history: Yes No

Does your criminal history include:

- Drug offenses or crimes against persons or property (ie: assault, theft):
- Offenses that make it exceedingly difficult to find housing: Arson, Placement on Sex Offender Registry, Production of Crystal Meth:
- Accused of wanting to hurt someone:
- DUIs, or a misdemeanor:

Have you in the past 3 months:

- Had any interactions with the police:
- Had any legal problems current or pending:
- Been arrested/incarcerated:

Are you currently Incarcerated and need a housing plan: Yes No