

# Western Continuum Pre-Screening Assessment

## (For General Public Assessments)

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.

May I please have your First Name:

Last Name:

And a telephone number in case we get disconnected:

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**

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

Yes

# Western Continuum Screening Tool

## Demographics

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In order to provide you with the best services I will ask you to answer a brief series of questions. The questions you provide will determine the next step necessary to help you with housing/homeless services and programs.

Interviewer:

Screening Date:

First Name:

Middle Initial:

Last Name:

Suffix:

Text: Yes No

Primary Phone Number:

Secondary Phone Number:

Email:

Date of Birth:

Birth Date Quality:

Full  
Approximate/Partial  
Client doesn't know  
Client refused

Age:

Soc. Security Number:

SSN Quality:

Full  
Approximate/Partial  
Client doesn't know  
Client refused

Race:

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

Client Doesn't Know

Client Refused

Ethnicity:

Hispanic/Latino  
Non-Hispanic/Latino  
Client doesn't know  
Client refused

Gender:

See Reference Sheet  
for choices

Primary Language:

## Education

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Last Grade Completed:

See Reference Sheet  
for choices

School Status:

## Homeless Assessment

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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? (see list above for choices)	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

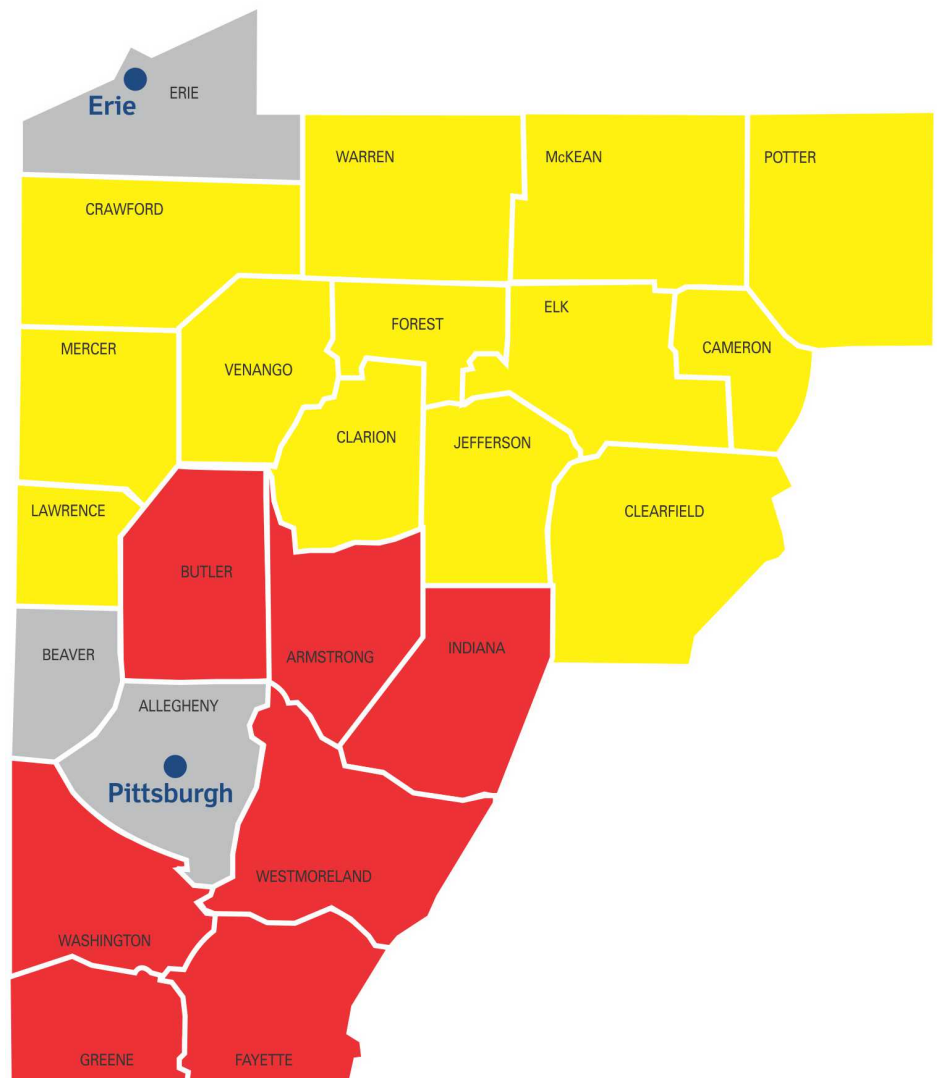
Potter County

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):

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**

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Domestic Violence Survivor:

- Yes
- No
- Client doesn't know
- Client refused



## Veteran Status

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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:

see Reference Sheet for choices

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**

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Are you employed:	Yes	No	Client Refused
Employment Status			Full-Time Part-Time Part-Time, looking for Full-Time Seasonal/Sporadic (Day Labor)
Number of hours a week: OR-			
Reason Not Employed:			Looking for work In school Unable to work Not looking for work Disabled with Supp. Income
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

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Family Type:

### Total Household: Dependents in Client's Care/Other Household Members

First Name	Last Name	Gender	Age	Birth Date	Relationship to HoH	Race	Ethnicity	Disabled Cond	Vet Status
		Male Female Trans Femail (MTF or Male to Female) Trans Male (FTM or Femail to Male) Gender Non-Conforming Client doesn't know Client refused			Parent Son Daughter Dependent Child Grandparent Guardian Spouse Other Family Other Non-Family Other Caretaker Ex-Spouse	American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White	Hispanic/Latino Non-Hispanic/Latino Client doesn't know Client refused	Yes No Doesn't know Refused	Yes No Doesn't know Refused

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

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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