Montgomery County Front Door Intake

Last Name of Head of Household:	First Name:	Middle Initial	Today's Date:
DOB:	Age:	SSN:	

Describe the circumstances that led you to come here today:

____

____

What do you need right now?

____

What is your plan for leaving the shelter?____

HOUSEHOLD TYPE

__ Single Adult __ Female Single Parent ___Male Single Parent ___Two Parent Family ___Foster Parent

__ Two or More Adults with no children <18 __Grandparent and Child __Non-custodial care giver __Other:_____

Number in Household: No. of Adults _____ No. of Children _____

Marital Status of Head of Household: married ☐ separated ☐ divorced ☐ single ☐

Housing Status ☐Category 1-Homeless ☐Category 2- At Imminent risk of losing housing ☐Category 3-Homeless only under other federal status ☐Category 4-Fleeing domestic violence ☐At-risk of homelessness ☐Stably housed ☐Client doesn't know ☐Client refused

HOUSEHOLD INFORMATION

List information about the people in your current household. Please start with the Head of Household (HOH):

First Name	Last Name	Gender	DOB	SSN	Relationship to HOH*	Custody if Child <18, Y or N	Veteran Y or N	Race	Ethnicity **	Disabled (Y or N)
1.Head of Household										
2.										
3.										
4.										
5.										

*Relationship to Head of Household: choose: self, spouse, partner, son, daughter, mother, father, sister, brother, grandparent
** Ethnicity: enter Hispanic/Latino [H/L] or Non-Hispanic/Latino [NHL]

Phone/Email for Household: (Repeat as necessary)

Name: [ ] Phone Number: [ ] Email: [ ]

Emergency Contact:

Name: [ ] Phone: [ ] Relationship: [pick from * list above]

Street Address: [ ] City, State, Zip: [ ]

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HOUSING ARRANGEMENTS: WHERE DID YOU STAY THE LAST NIGHT (before shelter)?

Street Address:	City	State	Zip
Facility or Program Name (if Applicable)		Monthly Cost to Live There: $___________________	

How long were you staying there? (Choose one)
☐ One week or less ☐ More than one week, but less than one month ☐ One to three months
☐ More than three months, but less than one year ☐ One year or longer ☐ Don't Know

Type of Housing/Accommodation: (Choose one)

☐Rental by client, no housing subsidy
☐Rental by client, with VASH housing subsidy
☐Rental by client, with other (non-VASH) housing subsidy
☐Owned by client, no housing subsidy
☐Owned by client, with housing subsidy
☐Staying or living in a family member's room, apartment or house
☐Staying or living in a friends room, apartment or house
☐Foster care home or foster care group home
☐Permanent housing for formerly homeless persons (such as SHP, S+C, SRO)
☐Long term care facility or nursing home
☐Residential project or halfway house with no homeless criteria
☐Emergency Shelter, including hotel or motel paid for with emergency shelter voucher
☐Hotel or motel paid without emergency shelter voucher
☐Transitional housing for homeless persons (including homeless youth)
☐Safe Haven
☐Psychiatric Facility
☐Substance Abuse treatment facility or detox center
☐Hospital or other non-psychiatric medical facility
☐Jail, prison, juvenile detention facility
☐Place not meant for habitation (e.g. a car, abandoned bldg., bus/train/subway station/airport or anywhere outside)
☐Rental by Client, with GPD TIP subsidy
☐Don't know
☐Other

Type of Housing Subsidy (if applicable): ☐ HAP ☐ GDPM ☐ ESPG ☐ Section 8 ☐ S+C ☐ SHP
☐ VA Supportive Housing (VASH) ☐None ☐Other: _______

What is the PRIMARY reason you left this housing? (Choose One)
☐ Eviction ☐ Unable to pay rent ☐ Utility shut off ☐ Domestic Violence
☐ Unsafe situation ☐ Fire ☐ Condemned property ☐ Foreclosure (renter)
☐ Foreclosure (owner) ☐ Overcrowded ☐ Conflict with others ☐ Moved from out of town
☐Discharge from program ☐ Physical illness ☐ Discharge from hospital ☐ Jail or Prison release
☐ Substance Use ☐Mental Illness ☐Other (please describe):

If you are being evicted, do you have a court date? ☐ Yes ☐ No Date you need to leave: month/day

If you were staying with family or friends, could you safely stay there if we offered you some help? ☐ Yes ☐ No

If yes, explain: ____

Conditions under which you could return to the place you stayed last night:
____
____

LAST PERMANENT RESIDENCE (if different from where you stayed last night)

Street Address:	City	State	Zip
Facility or Program Name (if Applicable)		Monthly Cost to Live There: $___________________	

How long were you staying there? (Choose one)
☐ One week or less ☐ More than one week, but less than one month ☐ One to three months

☐ More than three months, but less than one year ☐ One year or longer ☐ Don't Know

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Type of Housing/Accommodation: (Choose one)

☐Rental by client, no housing subsidy ☐Rental by client, with VASH housing subsidy ☐Rental by client, with other (non-VASH) housing subsidy ☐Owned by client, no housing subsidy ☐Owned by client, with housing subsidy ☐Staying or living in a family member's room, apartment or house ☐Staying or living in a friends room, apartment or house ☐Foster care home or foster care group home ☐Permanent housing for formerly homeless persons (such as SHP, S+C, SRO) ☐ Long term care facility or nursing home ☐Residential project or halfway house with no homeless criteria	☐Emergency Shelter, including hotel or motel paid for with emergency shelter voucher ☐Hotel or motel paid without emergency shelter voucher ☐Transitional housing for homeless persons (including homeless youth) ☐Safe Haven ☐Psychiatric Facility ☐Substance Abuse treatment facility or detox center ☐Hospital or other non-psychiatric medical facility ☐Jail, prison, juvenile detention facility ☐Place not meant for habitation (e.g. a car, abandoned bldg., bus/train/subway station/airport or anywhere outside) ☐Rental by Client, with GPD TIP subsidy ☐Don't know ☐Other

Type of Housing Subsidy (if applicable): ☐ HAP ☐ GDPM ☐ ESPG ☐ Section 8 ☐ S+C ☐ SHP
☐ VA Supportive Housing (VASH) ☐None ☐Other: _______

What is the PRIMARY reason you left this housing? (Choose one)
☐ Evicted ☐ Unable to pay rent ☐ Utility shut off ☐ Domestic Violence
☐ Unsafe situation ☐ Fire ☐ Condemned property ☐ Foreclosure (renter)
☐ Foreclosure (owner) ☐ Overcrowded ☐ Conflict with others ☐ Moved from out of town ☐
Discharge from program ☐ Physical illness ☐ Discharge from hospital ☐ Jail or Prison release
☐ Substance Use ☐Mental Illness ☐Other (please describe): ________________________

If you were staying with family or friends, could you safely stay there if we offered you some help? ☐ Yes ☐ No

If yes, explain: ____

Conditions under which you could return:

____

____

HOUSEHOLD INCOME

How much is your total monthly household income? $_______________

Have you had any change in your household income in the last three months? ☐ Yes ☐ No
If yes, please describe:____

Have you had any significant increases in household expenses over the last three months? ☐ Yes ☐ No
If yes, please describe:____

Please list all sources and amounts of monthly income for each adult 18 years or older in the household:

Head of Household Info	**First Name:**	**Last Name:**

Income Source	Amount	Income Source	Amount
Earned/Employment Income		TANF	
Unemployment Income		General Assistance	
Supplemental Security Income (SSI)		Retirement Income From Social Security	
Social Security Disability Income (SSDI)		Pension from Retirement	
VA Service Connected Disability		Child Support	
VA Non Service Connected Disability		Alimony or Other Spousal Report	
Private Disability Insurance		No financial resources	
Workers Compensation			

Non Cash Benefits You Receive

Food Stamps	☐ Yes ☐ No	Other TANF-funded Services	☐ Yes ☐ No
TANF Child Care Services	☐ Yes ☐ No	Section 8, public housing or other subsidy	☐ Yes ☐ No
TANF Transportation Services	☐ Yes ☐ No		

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Health Insurance You Receive

Covered by Health Insurance (If yes indicate all sources that apply)	☐ Yes ☐ No	VA Medical Services	☐ Yes ☐ No
Medicaid	☐ Yes ☐ No	Health insurance obtained through COBRA	☐ Yes ☐ No
Medicare	☐ Yes ☐ No	Private Health Insurance	☐ Yes ☐ No
State Health Insurance for Adults	☐ Yes ☐ No	Other:	☐ Yes ☐ No
State Health Insurance	☐ Yes ☐ No	Other:	☐ Yes ☐ No

Do you have a Bank Account? ☐ Yes ☐ No Checking $ _________ Savings $___________ Other $___________
Do you have any assets (e.g., car, property, CD, IRA, 401K)? ☐ Yes ☐ No
Other Relevant Information on income or assets: ____

Do you have any debts? ☐Yes ☐No - List totals
Utilities $________ Credit Card $_________ Medical Bills $_________ Car $________Overdue Child Support $_____
Rent $ ________ Mortgage $ ____________ Gambling $__________ IRS$_______Other: $________
Do you owe money to GDPM ☐Yes ☐No Total owed: $_____
Are your wages being garnished? ☐Yes ☐No If yes, what amount per month? ______________________________
If you pay child support, monthly amount? ________ Back payment amount? ________
Total Monthly debts $_________

Please list all sources and amounts of monthly income for each adult 18 years or older in the household:

Next Adult	**First Name:**	**Last Name**

Income Source	**Monthly Amount**	**Income Source**	**Amount**
Earned/Employment Income		General Assistance	
Unemployment Income		Retirement Income from Social Security	
Supplemental Security Income (SSI)		Child Support	
Social Security Disability Income (SSDI)		Alimony or other spousal support	
Veteran's Disability Non-service connected disability		Unemployment Insurance	
Private Disability Insurance		VA service connected disability	
Worker's Compensation		Pension or retirement income	
TANF		No financial resources	

Non Cash Benefits Received

Food Stamps	☐ Yes ☐ No	Other TANF-funded Services	☐ Yes ☐ No
TANF Child Care Services	☐ Yes ☐ No	Section 8, public housing or other subsidy	☐ Yes ☐ No
TANF Transportation Services	☐ Yes ☐ No	Special Supplemental Nutrition Program	☐ Yes ☐ No

Health Insurance You Receive

Covered by Health Insurance (If yes indicate all sources that apply)	☐ Yes ☐ No	VA Medical Services	☐ Yes ☐ No
Medicaid	☐ Yes ☐ No	Health insurance obtained through COBRA	☐ Yes ☐ No
Medicare	☐ Yes ☐ No	Private Health Insurance	☐ Yes ☐ No
State Health Insurance for Adults	☐ Yes ☐ No	Other:	☐ Yes ☐ No
State Health Insurance		Other:	☐ Yes ☐ No

Do you have a Bank Account? ☐ Yes ☐ No Checking $ _________ Savings $___________ Other $___________
Do you have any assets (e.g., car, property, CD, IRA, 401K)? ☐ Yes ☐ No
Other Relevant Information on income or assets: ____

Do you have any debts? ☐Yes ☐No - List totals
Utilities $________ Credit Card $_________ Medical Bills $_________ Car $________Overdue Child Support $_______
Rent $ ____________ Mortgage $ ____________ Gambling $__________IRS $______ Other: $________
Do you owe money to GDPM ☐Yes ☐No Total owed: $____________
Are your wages being garnished? ☐Yes ☐No If yes, what amount per month? ___________________________
If you pay child support, monthly amount? ________ Back payment amount? ________
Total Monthly debts $____________

Repeat above information as needed.

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SUPPORTS/INDEPENDENT LIVING

Has anyone been helping you recently? ☐Yes ☐ No

Name:______________________________________ Relationship ______________________________

Organization/Affiliation: ________________________ ______________________________

Phone #______________________________

If anyone has been helping you, is there anyone you might be able to stay with temporarily? ☐Yes ☐ No

If yes, Name: ____

Could you stay with this person while we work to help you find a more permanent place to live? ☐ Yes ☐ No
If yes, can you safely stay there? ☐ Yes ☐ No

What do you think it would take to arrange to stay with this person or family?
Explain:____

Do you have a case manager at another agency? ☐ Yes ☐ No
If Yes, Name: _______________________ Agency: __________________ Phone: __________________

Do you have an open case with Children's Services? ☐ Yes ☐ No
If Yes, Worker Name:________________________ Phone: ____________________

If you are receiving benefits like Social Security or SSI, do you have a representative payee? ☐ Yes ☐ No

If yes, Name: ____________________ Relationship: _____________ Phone number: __________________

If you are a member of your household is a Veteran, type of discharge:
☐ Honorable ☐ General ☐ Other than Honorable ☐ Bad Conduct ☐ Dishonorable

Do you have a disabling condition that prevents you from working or functioning well? ☐ Yes ☐ No ☐ Unknown
Please describe:____

Have you been homeless in the last year? ☐ Yes ☐ No
Have you been continuously homeless for at least one year? ☐ Yes ☐ No
How many times has client been homeless in the past three years? ☐1(homeless only this time) ☐ 2 times ☐3 times
☐4 times If 4 or more number of months homeless in the last 3 years _____
Is client chronically homeless ☐ Yes ☐ No

Do you have a physical disability that limits your mobility? ☐ Yes ☐ No ☐ Unknown
Please describe:____

Are there any restrictions on where you can live? ☐ Yes ☐ No
If yes, please describe: ____

Do you have any legal issues? ☐ Yes ☐ No
If yes, please describe: ____
Are you on ☐ Parole ☐Probation?
If so, what was the offense? ____

Is anyone in the household pregnant? ☐ Yes ☐ No
If yes, Name:____________________________ Due Date: month/year

Do you have Government Issued ID for the head of household? ☐ Yes ☐ No
If Yes, check all that you have: ☐ Driver's License ☐ Birth Certificate ☐ Passport ☐ Green Card
☐ Other Government Issued ID __________________

"What Schools are your children enrolled in?" Repeat as needed for multiple children
Child's Name: School Name: Location: Grade:

RISK ASSESSMENT (Refer to your agency' protocol for risk assessment)

Are you or anyone in your family on any federal or state sex offender registry? ☐ Yes ☐ No
If yes, describe: narrative text box – up to 2500 characters ____________________________
Observations of mental state – Intoxicated? Disorganized? Disoriented : ____________________
Health issues – current distress – bleeding, chest pains, nausea, etc.? ☐ Yes ☐ No

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Current Medications? ☐ Yes ☐ No
Do you have medications with you? ☐ Yes ☐ No
Acute suicidal/homicidal/medical issues? (Use agency suicide assessment protocol) ☐ Yes ☐ No
Need for Emergency Services? ☐ Yes ☐ No
Notes/summary

DIVERSION PLAN (if applicable):

Describe: ____________________

Street Address: ____________________ City, State, Zip Code: ____________________

Telephone #: ____________________

Diversion Type: ☐ Own Apt ☐ With Family ☐ With Friends ☐ Medical Hospitalization ☐ Detox ☐ Psychiatric Hospitalization ☐ Hotel/Motel ☐ Other: ____________________

*Front Door Comprehensive Assessment Domains**

Housing History – Last 5 years

Name/Location	**Type**	**Start**	**End Date**	**Leaseholder**	**Reason for Leaving**
	Pick list from Pg. 2			Yes or No	Pick list from page 2

- Ever evicted from GDPM housing? Y or N
- Restrictions on where can live Y or N with narrative explanation
- Was the head of household ever in foster care Y or N
- Barriers to Housing Stability (pick list and then space for “other” with a text box.) Pick list: Trouble budgeting, visitors create problems, involved in illegal activity, no experience as lease holder
- Housing Plan
- Who do you plan to have living with you when you leave here?
  Name :____________Age__________ Relationship ______________ Gender M/F
  (Allow multiple entries)
- Housing Goals
- Motivation to Obtain Housing: High, Medium, Low

Employment History – Last 5 Years

Employer	**Position/Title**	**Wage**	**Start**	**End**	**Reason for Leaving**
					Pick List
					Better job
					Quit
					Fired
					Laid Off
					Other:

- Employment Goals
- Services currently receiving
- Services Needed to Access or Maintain Employment
- Motivation to obtain employment: Pick High, Medium or Low

Benefits and Entitlements

- Status – pull from previous income screen and add start and end dates

Income Receiving	**Start Date/ End Date**		**Income Source**	**Start Date/ End Date**	
Earned/Employment Income			Workers Compensation		
Unemployment Income			TANF		
Social Security Income (SSI)			General Assistance		

*Front Door Comprehensive Assessment Domains**

Social Security Disability Income (SSDI)			Retirement Income from Social Security		
VA Service Connected Disability			Pension From Retirement		
VA Non Service Connected Disability			Child Support		
Private Disability Insurance			Alimony or other spousal report		

- Plan to apply for or maintain income benefits – text boxes for tasks and separate box for whose responsibility it is. Allow multiple tasks

• Task	• Responsible Party

Noncash Benefits – Pre-populate from intake assessment	**Y or N**		**Y or N**
Food Stamps	Y or N	Section 8, public housing or subsidy	Y or N
TANF Child Care Services	Y or N	Other TANF-funded Services	Y or N
Special Supplemental Nutrition Program	Y or N	Other: (list)	Y or N

Health Insurance You Receive

Covered by Health Insurance (If yes, indicate all sources that apply)	Y or N	VA Medical Services	Y or N
Medicaid	Y or N	Health Insurance Obtained by COBRA	Y or N
Medicare	Y or N	Private Health Insurance	
State Health Insurance for Adults		State Health Insurance	

- Plan to apply for or maintain noncash benefits – Allow multiple tasks

• Task	• Responsible Party

- Barriers to Obtaining/Maintaining Entitlements:

Debts

- Credit Status/Score

☐Car ☐Child Support(Back payment) ☐Child Support (Monthly payment) ☐Credit Card☐ GDPM ☐Gambling ☐Garnished Wage ☐IRS ☐Medical Bills ☐Mortgage ☐Rent ☐Utilities

- Plan to pay off debts
- Services Needed
- Motivation to resolve credit/debt issues: Pick High, Medium or Low
- Goals

Legal

- Legal Resident Y or N
- Probation/Parole Status to pre-populate from Intake Assessment
- Name of PO: _______________ Date Supervision Ends ____________

Felony history for last 5 years:

Date	Charge/Crime	Conviction: Pick Yes or No

Incarceration history for last 10 years:

Start Date	End Date	Facility	Reason/Charge

Brief narrative summary of involvement in the legal system: (Maximum 2500 characters)

- Current involvement – e.g., engaging in criminal activity, current legal proceedings, outstanding warrants, subject to order of protection, etc.
- Child support enforcement status
- Goals
- Services Needed
- Motivation to resolve legal issues: Pick High, Medium or Low

Education History

Highest Grade Completed: ☐ Some HS Last Grade completed :__________ ☐HS Diploma or GED ☐Some College ☐ Associate's Degree ☐Bachelor Degree ☐ Technical Certification - Field: _________ ☐Other_______

- Current status
  - ☐ In school Name of School: _________________
  - ☐ Applying Expected date of Enrollment: month/year
- Education Goals
- Services Requested

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*Front Door Comprehensive Assessment Domains**

Physical and Behavioral Health

- Where do you usually go for healthcare or when you're not feeling well? [pick specific hospital or clinic]
  - ☐ Community Health Centers of Greater Dayton
  - ☐ Charles Drew
  - ☐ Corwin Nixon
  - ☐ East Dayton
  - ☐ Miami Valley Hospital
  - ☐ Grandview Hospital
  - ☐ Good Samaritan Hospital
  - ☐ Samaritan Clinic/Health Care for the Homeless Clinic
  - ☐ Private doctor
  - ☐ VA
  - ☐ Fiver Rivers
  - ☐ Victor Cassano
  - ☐ Other: (name): _____________

- Do you have now, have you ever had, or has a healthcare provider ever told you that you have any of the following medical conditions?:

  a. Kidney disease/ End Stage Renal Disease or Dialysis: Yes☐ No☐ Refused
    If yes, are you: receiving treatment ☐ received treatment in the past ☐ not receiving treatment ☐
    If yes, have you been hospitalized for this in the past year? Yes☐ No☐
    Refuse ☐

  b. History of frostbite, hypothermia or immersion foot: Yes☐ No☐ Refused
    If yes, are you: receiving treatment ☐ received treatment in the past ☐ not receiving treatment ☐
    If yes, have you been hospitalized for this in the past year? Yes☐ No☐
    Refuse ☐

  c. Liver disease, Cirrhosis or End-Stage Liver Disease Yes☐ No☐ Refused
    If yes, are you: receiving treatment ☐ received treatment in the past ☐ not receiving treatment ☐
    If yes, have you been hospitalized for this in the past year? Yes☐ No☐
    Refuse ☐

  d. Heart disease, Arrhythmia or Irregular heartbeat: Yes☐ No☐ Refused
    If yes, are you: receiving treatment ☐ received treatment in the past ☐ not receiving treatment ☐
    If yes, have you been hospitalized for this in the past year? Yes☐ No☐
    Refuse ☐

  e. HIV+/AIDS: Yes☐ No☐ Refused
    If yes, are you: receiving treatment ☐ received treatment in the past ☐ not receiving treatment ☐
    If yes, have you been hospitalized for this in the past year? Yes☐ No☐
    Refuse ☐

  f. Emphysema: Yes☐ No☐ Refused
    If yes, are you: receiving treatment ☐ received treatment in the past ☐ not receiving treatment ☐
    If yes, have you been hospitalized for this in the past year? Yes☐ No☐
    Refuse ☐

  g. Diabetes: Yes☐ No☐ Refused
    If yes, are you: receiving treatment ☐ received treatment in the past ☐ not receiving treatment ☐
    If yes, have you been hospitalized for this in the past year? Yes☐ No☐
    Refuse ☐

  h. Asthma: Yes☐ No☐ Refused
    If yes, are you: receiving treatment ☐ received treatment in the past ☐ not receiving treatment ☐
    If yes, have you been hospitalized for this in the past year? Yes☐ No☐
    Refuse ☐

  i. Cancer: Yes☐ No☐ Refused
    If yes, are you: receiving treatment ☐ received treatment in the past ☐ not receiving treatment ☐
    If yes, have you been hospitalized for this in the past year? Yes☐ No☐
    Refuse ☐

  j. Hepatitis C Yes☐ No☐ Refused
    If yes, are you: receiving treatment ☐ received treatment in the past ☐ not receiving treatment ☐
    If yes, have you been hospitalized for this in the past year? Yes☐ No☐
    Refuse ☐

  k. Tuberculosis Yes☐ No☐ Refused
    If yes, are you: receiving treatment ☐ received treatment in the past ☐ not receiving treatment ☐
    If yes, have you been hospitalized for this in the past year? Yes☐ No☐
    Refuse ☐

*Front Door Comprehensive Assessment Domains**

l. high blood pressure, hypertension Yes☐ No☐ Refuse ☐
If yes, are you: receiving treatment ☐ received treatment in the past ☐ not receiving treatment ☐
If yes, have you been hospitalized for this in the past year? Yes☐ No☐
Refuse ☐

Programmer –If the individual answers yes to any of questions a-k above and has been hospitalized for it in the past year, make a referral to the Samaritan Clinic for a medical vulnerability assessment.

- Have you had a serious brain injury or trauma that required hospitalization or surgery? Yes No Refused
- How many times have you been to the emergency room in the past three months? ____________________
- How many times have you been hospitalized as an inpatient in the past year? ________________________
- How many times have you been hospitalized as an inpatient in the past 3 years? _______________________

- Are you currently or have you ever received treatment for mental health issues? Yes No Refused
- Have you ever been taken to the hospital against your will for mental health reasons? Yes No Refused

- Diagnosis: Medical, Mental Health, Substance Abuse, Mental Retardation, etc. - allow for multiple entries - include name, title and date for diagnosis
- Is the diagnosis documented by a qualified individual? Y or N
- Severity of Each Illness – In SP – “Description of Axis I, II, etc.” but not severity
- Current Treatment/Service Providers - Name, Organization and Phone Number (multiple entries)
- Previous Treatment Providers – Agency/Hospital, Dates of service – allow multiple entries
- Describe how health issues impact housing stability
  ☐paying rent ☐disruptive behavior ☐hoarding ☐noise ☐visitors
  Other: ____
- Has health insurance ☐ Y or ☐ N
- Current medications list
- Adherence to medication regimen Pick ☐ Almost Always ☐ Sometimes ☐ Never
- If substance abuse diagnosis, current status and impact on functioning
  ☐ Actively using and not a problem ☐ Actively using and a problem ☐Reducing use
  ☐ Abstinent: Date of Sobriety mm/dd/yy
- Frequency of Use: ☐ Daily ☐ Several Times Per Week ☐ Once a Week ☐ Less than 1X/week
- Types of substances used: pick list – pick all that apply: Cocaine, Prescription Drugs, Crystal Meth, Amphetamines, Heroin, Marijuana, Alcohol Other: list:
- Hospitalizations in last 3-5 years - Dates, Reasons, Hospital Names
- Detox in last 3 years – Number of inpatient detox stays – list of hospitals and clinics but not “detox”
- Services Needed
- Motivation to use services: pick Pre-contemplation, Contemplation, Preparation, Action, or Maintenance. Allow room for narrative explanation

Family/Dependent Children

- Domestic violence history
- Is Juvenile Parent
- School Attendance/Performance of children
- Child custody arrangements currently
- If you have children that are not with you, how many are there?
- Is there a reunification plan? Yes ☐ or No ☐
- Child care arrangements
- Special Needs
- Children’s Services Involvement – status, worker name and contact to pre-populate from page 5
- Goals
- Services Needed
- Motivation to use services: Pick High, Medium or Low

*Front Door Comprehensive Assessment Domains**

Independent Living Skills/ Supports

- Status of ID for all household members
- Nature of social and familial relationships – identify supports and significant others, also identify negative influences and relationships
- History of seeking and using help/assistance
- Goals

Independent Living Skills Checklist

1 - Mostly Independent 2 - Needs Help Sometimes 3 - Needs Help Most of the Time 4 - Always Needs Assistance

Item	Score
1. Paying bills	1-4
2. Budgeting	1-4
3. Maintaining entitlements and other paper work	1-4
4. Maintaining a home	1-4
5. Preparing/Obtaining meals	1-4
6. Travelling	1-4
7. Personal Care/hygiene	1-4
8. English Proficiency	1-4
9. Awareness of needs and knowing when to seek help	1-4
10. Able to access help when needed	1-4
11. Managing health/behavioral health needs and services, etc.	1-4
12. Taking medications	1-4
13. Keeping Appointments	1-4
14. Discriminating danger/asserting and protecting self	1-4
Total Score on Independent Living Skills (Range 14-56)	

- Ability and motivation to improve skills: Pick High, Medium or Low

Front Door Housing Barriers Screen

This form aims to capture some common housing stability barriers facing homeless people and those at risk of homelessness. Much of the information can be found in the intake form. The rest can be gathered directly from the participant. Some information may be unknown or people may refuse to answer. This is to be expected, although it would be preferable to have as much information as possible. The housing barriers screen should be used to develop Housing Plans for each household and for re-assessments for those that receive ongoing assistance. CHECK ALL THAT APPLY.

Income
- ☐ No income
- ☐ Has income but it's below 30% of AMI
- ☐ Recent decrease in income
- ☐ Receiving unemployment or other income that is time-limited
- ☐ Sanctioned or timed out on TANF
- ☐ Paying more than 50% of income for rent

Score _____ of 6

Debts/Expenses
- ☐ Recent increase in monthly expenses
- ☐ Monthly obligations exceed monthly income
- ☐ Poor credit history
- ☐ Currently in bankruptcy
- ☐ Debts to the utility company

Score _______ of 5

Employment
- ☐ No High School Diploma or GED
- ☐ Unemployed
- ☐ Currently in temporary or seasonal job
- ☐ Inconsistent work history – gaps in employment or frequent changes in jobs
- ☐ Lacks adequate transportation

Score _____ of 5

Legal Issues
- ☐ Subject to Child Support Enforcement – e.g., garnish wages
- ☐ On parole
- ☐ On probation
- ☐ History of incarceration
- ☐ Felony within last 5 years
- ☐ Restrictions on housing location – e.g., sex offender, DV
- ☐ Undocumented immigrant

Score _____ of 7

Housing History
- ☐ Homeless in the last 12 months: (✓ if currently homeless)
- ☐ Multiple episodes of homelessness
- ☐ Chronically homeless or on long stayer list
- ☐ One or two legal evictions
- ☐ More than 2 evictions
- ☐ Never had own lease
- ☐ Lack of rental history of more than 1 year
- ☐ Barred from public housing for eviction or other threshold status (crystal meth, etc.)
- ☐ Evicted from other subsidized housing
- ☐ History of institutional care – e.g., state hospital, foster care, prison

Score _____ of 10

Family Status
- ☐ Custody of 3 children
- ☐ Custody of 4 or more children
- ☐ 1 or more custodial children < age of 5
- ☐ Single adult under age 22
- ☐ Head of household under 25 years old with children or pregnant
- ☐ Current or past involvement with foster care system
- ☐ Unmet child care needs
- ☐ Domestic violence survivor
- ☐ Has child with special needs
- ☐ Children not attending school regularly

Score _____ of 10

Health/Disability
- ☐ Chronic physical illness
- ☐ Health crisis, detox or hospitalization in the past year
- ☐ Ongoing medical needs and no health insurance
- ☐ One disabling condition such as mental illness, SA
- ☐ Multiple disabling conditions
- ☐ Disabling condition has negatively affected housing stability
- ☐ Not in treatment for ongoing, health, mental health or substance abuse issues

Score _____ of 7

Supports/Independent Living Skills
- ☐ No or limited support networks
- ☐ History of being unable or unwilling to seek help
- ☐ Engaged in abusive relationship
- ☐ Limited English proficiency
- ☐ Never had driver's license
- ☐ Hoards to point of a health or safety risk
- ☐ History of problem visitors in past housing
- ☐ No Government Issued ID for any household member
- ☐ Does not have 2 landlord references

Score _____ of 9

Subtotal ____________ of

Subtotal ____________ of

Total ________ of 59 Level of Need: ☐ High ☐ Medium ☐ Low

1/9/15