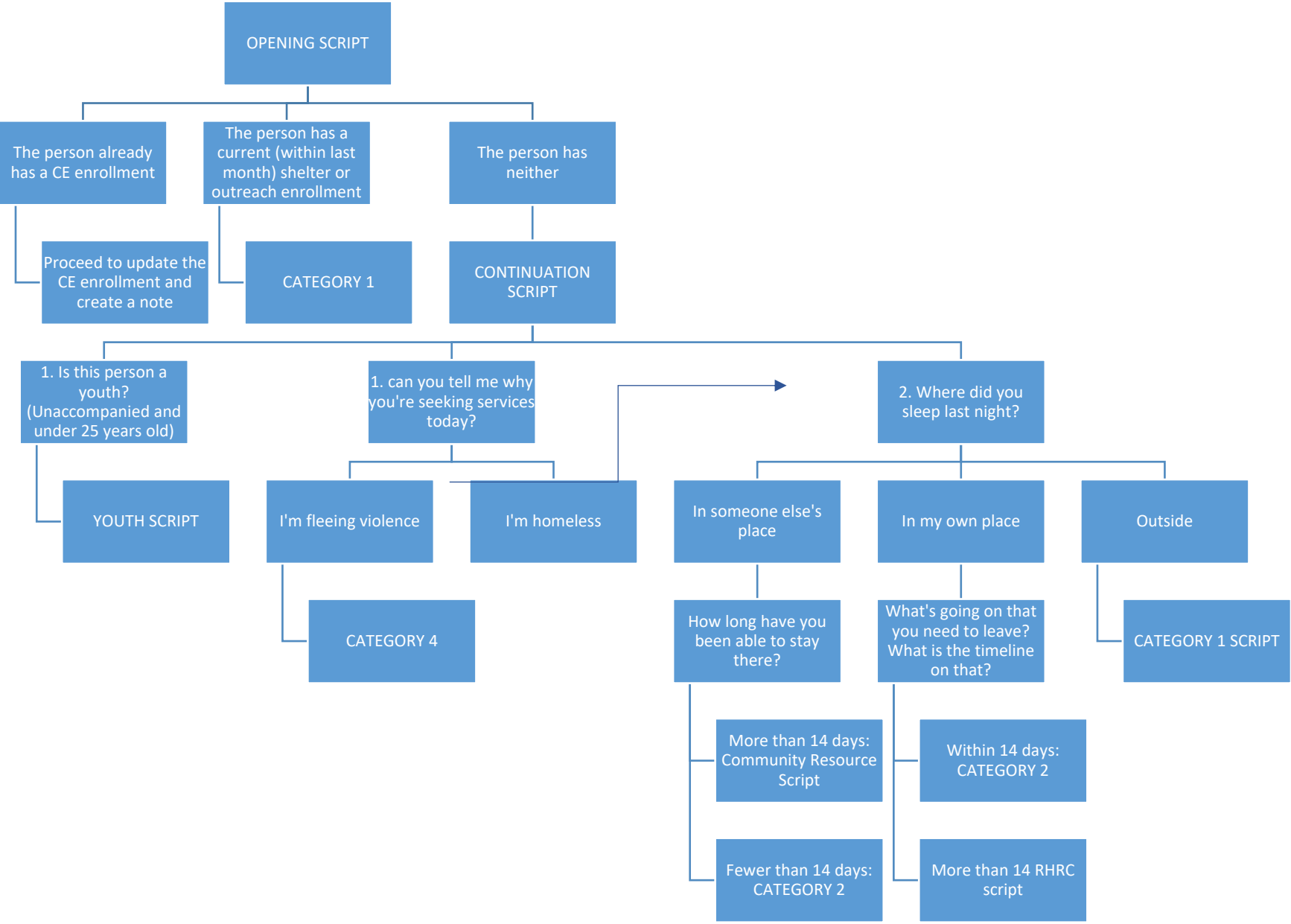


Coordinated Entry Assessment 2.0



Coordinated Entry Assessment 2.0

OPENING SCRIPT

- I'm glad we're talking! My name is _____ and I'm going to get you started with the first step in the Coordinated Entry process. Can I have your name and date of birth? (Use this to look them up in Clarity and, if there is a profile, look at the program enrollments to determine current category status. If open enrollment in shelter or street outreach, jump to Category 1 script- verified.)

CONTINUING SCRIPT

- So, the program that I work in is specific to people who are homeless by HUD's definition. I have some questions to go through with you, and we'll talk about options after that. Is that okay?

CATEGORY 1 SCRIPT- unverified

- If you're sleeping outside at night, I'd like to know where so that we can try to have street outreach look for you. Can you tell me where you're staying? (refer to outreach)

CATEGORY 1 SCRIPT- verified

It looks like we can do a Coordinated Entry enrollment for you. What this will do is let our team know that you're in need of housing. As resources become available, we may be able to refer you to housing. We'll work closely with your case manager/outreach worker, so stay in good contact with them. Also, it's good to keep your options open, so keep working on housing on your own and with your support team. This is another potential housing resource, but isn't a guarantee. Would you like to proceed?

YOUTH SCRIPT (including Category 3)

- Pathfinders is an agency that specializes in working with folks your age, and then can talk through next steps with you. Have you been there before? Their drop in hours are Tuesdays and Fridays from 1-6pm at 4200 N Holton Street.
- I can continue an assessment here if you'd like to see if you also qualify for any of our services, would you like that? (If yes, gather information on Categories 1, 2, and 4).

CATEGORY 4 SCRIPT

- I'm so sorry to hear that. There are domestic violence shelters that you can get in touch with for services, would you be interested in that? These resources are separate from Coordinated Entry, but should be able to advise you on the best next step for you. (Note- if all of the DV shelters are full, we can consider you for homeless resources. In this instance, make Jodi aware of the shelter need.)
- I can also complete an assessment for long-term housing services if that is something you're seeking. The DV providers can also do this. Would you like to complete this with me? (If yes, continue to CE assessment, if no, refer out.)

CATEGORY 2 SCRIPT

- I can do an assessment today that could provide you with case management services to try to avoid coming into homelessness. Would you like that? (Prevention Assessment) I'm going to do this assessment which will put you on our needs list for case management. It's good to keep your options open, so keep working on housing on your own and with your support team. This is another potential resource, but isn't a guarantee.

Coordinated Entry Assessment 2.0

COMMUNITY RESOURCES SCRIPT

- More than 2 weeks: I'm so glad you have that resource. It sounds like you're seeking resources for housing. (Assess for resources to support income and independent housing and refer via IMPACT Connect/Unite Us.) [Note: If they state they need shelter, it's okay to say: emergency shelter is a resource for people who are already outside. I want to focus on how we can get you housed.]

RHRC SCRIPT

It looks like you could use support with your current unit and landlord. We aren't the experts in that, but can refer you to our colleagues at the Rental Housing Resource Center who are the experts. (Make a referral through Unite Us/IMPACT Connect)

CATEGORY 1.5

We can connect you supportive services for housing either way, but I want to make sure that you get connected as quickly as possible. If you are regularly outside, the first step is to get connected to a street outreach team. Are you outside regularly enough for an outreach team to find you? (YES= CATEGORY 1) Otherwise, we can connect you to a case manager to work on housing while you're going from place to place. (CATEGORY 2)

SPECIFIC PROGRAM ASKS

All of our programs require these initial assessments, and have different eligibility requirements because of HUD. I'd like to talk through what your situation is and then we can talk about what you might be eligible for.

Coordinated Entry Assessment 2.0

CE Assessment Tool

1. Does this person fit any of the following specific populations? Check all that apply:

Veteran- *tickler for a referral to CVI, continues to proper queue*

Over 55- *tickler to refer to elderly housing lists, continues to proper queue*

Diagnosed with HIV/AIDS- *tickler to refer to Vivent, continues to proper queue*

Family- *used to add to Family Queue*

Drop Down to family questions

Youth (ages 18-24)- *used to add to Youth Queue*

Drop Down of youth questions

Fleeing DV- *used to add to Category 4 Queue*

Drop Down of DV assessment

Chronic- *used to add to PSH Queue*

Drop Down of 3.917 questions + disability question (y/n)

Struggling in Shelter due to Behavioral Health- *used to add to Safe Haven Queue*

Drop Down of Safe Haven assessment

[aspirationally] Struggling in Shelter due to Physical Health- *used to add to medical respite queue*

2. Where did this person sleep last night?

Verified in shelter or outside- Add to appropriate population queue

Other- Add to prevention queue (and maybe youth/category 4 queues)

Drop Down of prevention assessment

3. For all Category 1 people, use the following assessment:

3.917 Questions + disability question (y/n)- used for RRH w/ repeated episodes and total months homeless

And, for vulnerability score (low=more vulnerable), yellow cells indicate need for intensive CM services, pink cells indicate need for long-term subsidy, red cells indicate need for evaluation for PSH:

Coordinated Entry Assessment 2.0

Client Name:				Client HMIS ID:		
Case Manager:				Assessment Date:		
Housing, Income, Health, Supportive Services & Mainstream Resources	Score: 5	Score: 4	Score: 3	Score: 2	Score: 1	Score
1. Sheltering History	Currently outside and declining shelter due to behavioral health concerns.	Has been asked to leave shelter and has been denied on reassessment and/or Potential problems/concerns with shelter and still outside.	Has been asked to leave shelter at least once And/or Is currently outside with no shelter availability	Has had many short shelter stays	Is currently in shelter/housed	
2. Outstanding Rent Arrears	Person has outstanding rent arrears and is not willing to set up a payment plan	Person has more than 6 months in current rent arrears and has set up a payment plan or applied for resources	Person has less than 3 months in current rent arrears and is current on payment plans	Person has no current arrears and does not have a current payment plan for past bills	Person has never accrued rent arrears	
3. Past Evictions	Person has multiple evictions with outstanding restitution for rent or damages	Person has eviction(s) in the past 3 years and restitution has been cured	Person has eviction(s) in the past 5 years and restitution has been cured	Person has eviction(s) in the past 7 years and restitution has been cured	Person has no evictions	
4. Maintaining or Increasing Income	Person has no income and has not yet applied for benefits and/or employment	Person has zero income and has applied for benefits and/or employment	Persons income is temporary, part-time or seasonal; inadequate pay	Person is receiving benefits or is currently employed	Person income from benefits and/or employment has increased from the previous year	

Coordinated Entry Assessment 2.0

5. Substance Use	Person's substance misuse currently interferes with daily living and is in the pre-contemplative stage of change.	Person's substance misuse currently interferes with daily living and is in the contemplative stage of change.	Person's substance misuse interferes with daily living, but is seeking treatment/change options.	Person is in the active stage of change and is working on a plan for recovery, may be in recovery or may be reducing use/harm	Person has engaged in 6+ of months of active change, or is in recovery, or has no substance misuse	
6. Mental Health Care Use	Person has not had contact with a mental health provider in the past 12 months and has active mental health symptoms that interfere with daily living	Person has made 1 documented mental health care appointment in last 12 months and has active mental health symptoms that interfere with daily living	Person has made 2 or more documented mental health care appointments in the last 12 months and may be in mental health recovery	Person is able to keep mental health care appointments as recommended on a regular basis and is in mental health recovery	Person has sustained recovery for 24+months or no diagnosed mental illness	
7. Medication Adherence	Person self-reports not taking any medications as prescribed	Person self-reports rarely (only when symptomatic) taking prescribed medications	Person self-reports irregularly taking prescribed medications with minimal missed doses	Person self-reports regularly taking prescribed medications without missed doses	Person has sustained medication adherence for 24+ months or no prescribed medications	
8. Connection to Mainstream Primary Health Care	Person is not connected to any mainstream resources and/or has not had contact with primary health care provider in past 12 months	Person is newly connected to mainstream resources (selected provider and has completed initial intake, assessment, or referral process)	Person has been connected to mainstream resources for the past 6 month, but often misses appointments	Person has been connected to mainstream resources for the past 12 months, but often misses appointment	Person is connected to mainstream resources, has a primary healthcare provider and keeps appointments as recommended	
9. Connection to Community Supports	Person has no community supports; socially isolates or lacks motivation to become involved	Person lacks knowledge of ways to become involved; new to the community	Person has limited community supports and is not interested in attaining others	Person has adequate community supports in neighborhood	Person seeks out community supports and has many connections including specialized services	

Coordinated Entry Assessment 2.0

10. Clinical Crisis Intervention	Person has required over 5 clinical crisis interventions in the past 12 months	Person required 3-5 clinical crisis interventions in the past 12 months	Person required clinical crisis intervention in the past 12 months, and worked quickly with case manager to identify needs and help	Person has not required clinical crisis intervention in the past 12 months	Person has no history of clinical crisis intervention	
11. Legal	Current outstanding tickets or warrants or other serious unresolved legal issues (0 points if a registered sex offender)	Current charges/trial pending; noncompliance with probation/parole	Fully compliant with probation/parole terms and/or no new charges filed within the past 3 years	Has successfully completed probation/parole; no new charges filed within the past 5 years	No felony criminal history and/or no active criminal justice involvement in past 7 years	
12. Physical Vulnerability	Is over 70 or under 25 and has multiple medical conditions And/or Is over 70 and under 25 and has been physically attacked in the last month	Has multiple medical conditions And/or Has been physically attacked in the last month	Is over 70 or under 25	Person has some risk factors due to health and/or age that could make them physically vulnerable	Is physically healthy	
13. Interpersonal Skills	Struggles to get along with others, is regularly getting into fights, asked to leave buildings/programs	Struggles to get along with others, prefers isolation and may become aggressive when around others	Is able to get along with others but may struggle due to past trauma or mental health symptoms	Is able to get along with others well	Is actively involved in community/peer groups	
Total Score: (Total Possible Score Range 13-65)						