



## Coordinated Entry Housing Assessment Adult/Adult Couples

**This packet should be used for adults 25 or older (singles or couples) without minor dependents. Each adult in a household will need to complete a separate packet.**

### Table of Contents

I. INSTRUCTIONS .....	1
Privacy Practices .....	1
Check Age/Household Type .....	1
All Adults Must Be Assessed Separately .....	1
Check for earlier assessments.....	1
II. INTRODUCTORY PARAGRAPH .....	2
III. HMIS DATA ELEMENTS.....	3
IV. VI-SPDAT .....	7

#### I. INSTRUCTIONS

##### Privacy Practices

Please remember to follow the Anchorage Continuum of Care and Coordinated Entry Privacy Practices when sharing someone’s information in HMIS and entering a client into Coordinated Entry. The most up to date Privacy Practices will always be posted on the Anchorage Coalition to End Homelessness’ website: [www.anchoragehomeless.org](http://www.anchoragehomeless.org).

##### Check Age/Household Type

Please remember that this packet is meant for people 25+. If the client you are serving is 24 or under, please complete the TAY assessment packet. If the household you are serving includes a minor or if a household member is pregnant, please complete the Family Assessment Packet.

##### All Adults Must Be Assessed Separately

When completing an adult assessment, please remember that all adults (over the age of 18) must receive their own assessment and entry into Coordinated Entry. Adult couples or families with only adult members may be housed together, however, they must be assessed separately. If there are minors in the household, please complete a family packet and follow the protocol for how to assess a family with minor dependents as a household.

##### Check for earlier assessments

Please remember to check to see if a client already has an open CE entry in HMIS. You may need to check multiple HMIS client IDs. If a client already has an active assessment under any client number, please do not complete a second assessment in HMIS. If information (including a VI-SPDAT) needs to be updated, please complete this packet and input as an “interim review” in the system.

## II. INTRODUCTORY PARAGRAPH

Hello. I'm here today to talk to you about your housing and service needs. The purpose of this assessment is to identify what services in town will best suit your needs, help community providers identify gaps in our current social service system, and to determine the order in which people will be contacted for housing and related services. It is important that you know that this is not a guarantee for housing or services, nor is this a guarantee of assistance within a specific time period. The Coordinated Entry System does not prioritize individuals on a first-come-first-serve basis which means individuals served by Coordinated Entry will wait for various lengths of time before receiving a referral to services.

The Coordinated Entry Process will do its best to use the information collected here to provide referrals that are appropriate to your needs and program eligibility. It is important to know, however, that this is not an application for housing or services. Once you receive a referral there may be additional information that your service agency will need to collect to ensure that you meet the requirements for their program. Receiving a referral through Coordinated Entry is not a guarantee of services until your specific program confirms eligibility. If in any circumstance you are referred to a service for which you are not eligible, you will remain prioritized for services through Coordinated Entry and can receive future referrals to other programs as availability arises.

In this assessment there will be questions asked about past housing and services, your current health, substance use, legal involvement, financial stability and other areas related to housing and service need. The answers you provide in this assessment will not qualify or disqualify for Coordinated Entry, but rather help us identify which services will best suit your needs. It is always best to be honest when answering these questions. Some of these questions will be personal could make you feel uncomfortable. If there is anything that you do not want to talk about, please let me know. You always have the right to refuse to answer a question, and we can move to the next part of the assessment. Please know, however, that the more information you can provide me, the more able I am to understand your current situation and help you with what you really need.

Do you have any questions?

May we proceed?

### III. HMIS DATA ELEMENTS

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Completed By: \_\_\_\_\_

Agency: \_\_\_\_\_

Phone Number \_\_\_\_\_

Other Place to Contact in Future/Time Best Found: \_\_\_\_\_

Message Line: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Client Information:**

Full Name	Date of Birth	SSN (full or partial)

Are you a U.S. Military Veteran?  Yes  No

**Instructions:** Please enter military status under the client profile in HMIS as this question is not included in the CE entry.

<p><b>Gender:</b></p> <p><input type="checkbox"/> Female <span style="margin-left: 100px;"><input type="checkbox"/> Gender Nonconforming</span></p> <p><input type="checkbox"/> Male <span style="margin-left: 100px;"><input type="checkbox"/> Client Doesn't Know</span></p> <p><input type="checkbox"/> Trans (Male to Female) <span style="margin-left: 50px;"><input type="checkbox"/> Client Refused</span></p> <p><input type="checkbox"/> Trans (Female to Male)</p>	<p><b>Ethnicity:</b></p> <p><input type="checkbox"/> Non -Hispanic/Non-Latino <span style="margin-left: 50px;"><input type="checkbox"/> Client Doesn't Know</span></p> <p><input type="checkbox"/> Hispanic/ Latino <span style="margin-left: 100px;"><input type="checkbox"/> Client Refused</span></p>
--	--

<p><b>Primary Race:</b></p> <p><input type="checkbox"/> American Indian/Alaska Native <span style="margin-left: 100px;"><input type="checkbox"/> Client Doesn't Know</span></p> <p><input type="checkbox"/> Asian <span style="margin-left: 100px;"><input type="checkbox"/> Client Refused</span></p> <p><input type="checkbox"/> Black/African American</p> <p><input type="checkbox"/> Native Hawai'ian/Pacific Islander</p> <p><input type="checkbox"/> White</p>	<p><b>Secondary Race (Optional):</b></p> <p><input type="checkbox"/> American Indian/Alaska Native <span style="margin-left: 100px;"><input type="checkbox"/> Client Refused</span></p> <p><input type="checkbox"/> Asian <span style="margin-left: 100px;"><input type="checkbox"/> Client Doesn't Know</span></p> <p><input type="checkbox"/> Black/African American</p> <p><input type="checkbox"/> Native Hawai'ian/Pacific Islander</p> <p><input type="checkbox"/> White</p>
---	--

Do You Have Health Insurance?  Yes  No  Client Doesn't Know  Refused

*If yes, please identify all types of currently active insurance below:*

<p><input type="checkbox"/> Medicaid</p> <p><input type="checkbox"/> Medicare</p> <p><input type="checkbox"/> State Children's Health Insurance Program</p> <p><input type="checkbox"/> Veteran's Administration (VA) Medical Services</p> <p><input type="checkbox"/> Employer-Provided Insurance</p>	<p><input type="checkbox"/> Health Insurance through COBRA</p> <p><input type="checkbox"/> Private Pay Insurance</p> <p><input type="checkbox"/> State Health Insurance for Adults</p> <p><input type="checkbox"/> Indian Health Insurance</p> <p><input type="checkbox"/> Other: _____</p>
--	---

Do you have a disabling condition?  Yes  No  Client Doesn't Know  Refused

Please indicate all types of disability below:

Disability Type	Disability Determination	<b>IF YES:</b> Is Condition Expected to be Long-Term and Impede ability to Live Independently?
Alcohol Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
Developmental	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mental Health Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No

Notes on disability/disabilities:

---



---



---



---



---

### Alaska Mental Health Trust Authority Beneficiary Information

Alzheimer's Disease and Related Dementias	Chronic Alcoholism or other Substance Use Disorder	Intellectual or Developmental Disabilities	Mental Illness	Traumatic Brain Injuries	Start Date __/__/__
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Refused	End Date __/__/__

### Client Location – ALWAYS ANCHORAGE

Please indicate Anchorage-500 for client location in HMIS.

If client's primary residence is outside of the municipality of Anchorage, please do not complete an Anchorage Coordinated Entry Packet and refer to services within their regular municipality.

## SITUATION PRIOR TO PROJECT ENTRY

### Section I

#### Where did you sleep last night?

**Instructions:** **SELECT ONLY ONE OPTION FROM ONE OF THE HIGHLIGHTED CATEGORIES (options 1, 2, or 3) below.** For example, if the client was in a shelter, select that from the Homeless Situation category and continue with complete Sections II - IV.

#### **1. Homeless Situation**

Client doesn't know     Client refused

- Place not meant for habitation (e.g. outside, in a car, in a tent)
- Emergency shelter, including hotel or motel **paid for with emergency shelter voucher**
- ~~Safe Haven~~ (not currently available in Alaska)
- Interim Housing

#### **2. Institutional Situation**

- Foster care home or foster care group home
- Hospital or other residential non-psychiatric medical facility
- Jail, prison or juvenile detention facility
- Long-term care facility or nursing home
- Psychiatric hospital or other psychiatric facility
- Substance abuse treatment facility or detox center

#### **3. Transitional and Permanent Housing Situation**

- Hotel or motel paid for **without** emergency shelter voucher
- Owned by client, no ongoing housing subsidy
- Owned by client, with ongoing housing subsidy
- Permanent housing (other than RRH) for formerly homeless persons
- Rental by client, no ongoing housing subsidy
- Rental by client, with VASH subsidy
- Rental by client, with GPD TIP subsidy
- Rental by client, with other ongoing housing subsidy (including RRH)
- Residential project or halfway house with no homeless criteria
- Staying or living in a family member's room, apartment or house
- Staying or living in a friend's room, apartment or house
- Transitional housing for homeless persons (including homeless youth)

### Section II

Please complete all remaining sections:

#### **\* Length of Stay at Prior Night Living Situation:**

- |  |   |
|--|---|
| <input type="checkbox"/> One night or less                         | <input type="checkbox"/> One month or more, but less than 90 days |
| <input type="checkbox"/> Two to six nights                         | <input type="checkbox"/> 90 days or more, but less than one year  |
| <input type="checkbox"/> One week or more, but less than one month | <input type="checkbox"/> One year or longer                       |
| <input type="checkbox"/> Client doesn't know                       | <input type="checkbox"/> Client refused                           |

Approximate date most recent episode of homelessness started: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

#### **Instructions for most recent episode:**

\* Look for the most recent "break" in homelessness to identify the start of current episode. Breaks include 7+ nights in a permanent or temporary housing situation; 90+ days in an institution.

\* If someone is actively in an institution, has been there for less than 90 days, and was experiencing homelessness before entering the institution, look for the most recent break in homelessness prior to institutionalization.

\* If someone was in a permanent or transitional housing situation last night, but will be experiencing homelessness tonight, please use today's date.

**Section III**

**\* Regardless of where they stayed last night—Number of separate times/episodes the client has been on the streets or in emergency shelter in the past three years (counting current stay):**

- One time     
  Two times     
  Three times     
  Four or More Times  
 Client doesn't know     
  Client refused

**Section IV**

**Total number of months homeless on the street or in emergency shelter in past 3 years:**

- 1 month (this time is the first time)  
  2 months  
  3 months  
  4 months  
  5 months  
 6 months  
  7 months  
  8 months  
  9 months  
  10 months  
  11 months  
  12 months  
 More than 12 months  
  Client doesn't know  
  Client refused

**Total number of months homeless on the street or in emergency shelter in past 3 years (up to 36 months):**

**Instructions:** If the client has spent less than 12 months in a HUD defined homeless situation in the last three years, please repeat the answer provided above here. If the client has experienced homelessness for over 12 months, please specify up to 36 months.

\_\_\_\_\_ Total number of months (Up to 36 months)

**INCOME AND NON-CASH BENEFITS**

**Do You Have Income from Any Source?**

- Yes  
  No  
  Client Doesn't Know  
  Refused

*When entering into HMIS, please include total calculation from "View Gross Income" in the "Total Monthly Income" box.*

Type	Currently Receiving?	Amount
Alimony or Other Spousal Support.	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
TANF	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Child Support	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Earned Income	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
General Assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Pension or retirement income	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Private Disability Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
SSDI	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
SSI	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Retirement Income from Social Security	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Unemployment Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
VA Service Connected Disability Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
VA Non-Service Connected Disability Pension	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Worker's Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Other (please specify): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____

**Do You Receive Any Non-Cash Benefits from Any Source?**

- Yes  
  No  
  Client Doesn't Know  
  Refused

TANF Child Care Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
TANF Transportation Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Other TANF-Funded Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Special Supplemental Nutrition Program for WIC	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Supplemental Nutrition Assistance Program (Food Stamps)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
Other (please specify): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____

**DOMESTIC VIOLENCE**

Are you a victim/survivor of domestic violence?  Yes  No  Client Doesn't Know  Refused

If yes, please answer both questions below:

**When did this experience occur?**

- Within last 3 months  3 – 6 months ago  6 – 12 months ago  More than a year ago  
 Client doesn't know  Refused

**Are you currently fleeing?**

- Yes  No  Client Doesn't Know  Refused

If currently fleeing, assess for safety and provide a referral to AWAIC or other victim service providers as appropriate.

Primary Alaska Native Regional Corporation	Secondary Alaska Native Regional Corporation (Optional).
<input type="checkbox"/> Ahtna <input type="checkbox"/> Goldbelt <input type="checkbox"/> Aleut <input type="checkbox"/> Koniag Incorporated <input type="checkbox"/> Arctic Slope <input type="checkbox"/> NANA <input type="checkbox"/> Bering Straits <input type="checkbox"/> Sealaska <input type="checkbox"/> Bristol Bay <input type="checkbox"/> 13 <sup>th</sup> Regional <input type="checkbox"/> Calista. <input type="checkbox"/> Descendent, BIA card only <input type="checkbox"/> Chugach <input type="checkbox"/> "Z" Not Affiliated <input type="checkbox"/> Cook Inlet <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Doyon <input type="checkbox"/> Client Refused	<input type="checkbox"/> Ahtna <input type="checkbox"/> Goldbelt <input type="checkbox"/> Aleut <input type="checkbox"/> Koniag Incorporated <input type="checkbox"/> Arctic Slope <input type="checkbox"/> NANA <input type="checkbox"/> Bering Straits <input type="checkbox"/> Sealaska <input type="checkbox"/> Bristol Bay <input type="checkbox"/> 13 <sup>th</sup> Regional <input type="checkbox"/> Calista. <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Chugach <input type="checkbox"/> Client Refused <input type="checkbox"/> Cook Inlet <input type="checkbox"/> Doyon

**IV. VI-SPDAT**

**Instructions:** Interviewer must have completed the online VI-SPDAT training module. The total score will be calculated in AKHMIS. Upload the VI-SPDAT document into AKHMIS by scanning the packet and attaching it as PDF file.

**A. History of Housing and Homelessness**

1. Where do you sleep most frequently? (check one)

- Shelters  
 Transitional Housing  
 Safe Haven  
 Outdoors  
 Other (specify):

\_\_\_\_\_  Refused

2. How long has it been since you lived in permanent stable housing?

\_\_\_\_\_  Refused

3. In the last three years, how many times have you been homeless?

\_\_\_\_\_  Refused

## B. Risks

4. In the past six months, how many times have you... \_\_\_\_\_  Refused
- a) Received health care at an emergency department/room? \_\_\_\_\_  Refused
- b) Taken an ambulance to the hospital? \_\_\_\_\_  Refused
- c) Been hospitalized as an inpatient? \_\_\_\_\_  Refused
- d) Used a crisis service including sexual assault crisis, mental health crisis, family/intimate violence, distress centers and suicide prevention hotlines? \_\_\_\_\_  Refused
- e) Talked to police because you witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime, or because the police told you that you must move along? \_\_\_\_\_  Refused
- f) Stayed one or more nights in a holding cell, jail or prison, whether that was short-term stay like the drunk tank, or a longer stay for a more serious offence, or anything in between? \_\_\_\_\_  Refused
5. Have you been attacked or beaten up since you've become homeless?  Yes  No  Refused
6. Have you threatened to or tried to harm yourself or anyone else in the last year?  Yes  No  Refused
7. Do you have any legal stuff going on right now that may result in you being locked up, having to pay fines, or that make it more difficult to rent a place to live?  Yes  No  Refused
8. Does anybody force or trick you to do things that you do not want to do?  Yes  No  Refused
9. Do you ever do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone you don't know, share a needle, or anything like that?  Yes  No  Refused

## C. Social & Daily Functioning

10. Is there any person, past landlord, business, bookie, dealer, or government group like the IRS that thinks you owe them money?  Yes  No  Refused
11. Do you get any money from the government, a pension, an inheritance, working under the table, a regular job, or anything like that?  Yes  No  Refused
12. Do you have planned activities, other than just surviving, that make you feel happy and fulfilled?  Yes  No  Refused
13. Are you currently able to take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water, and other things like that?  Yes  No  Refused
14. Is your current homelessness in any way caused by a relationship that broke down, an unhealthy or abusive relationship or because family or friends caused you to become evicted?  Yes  No  Refused



#### D. Wellness

15. Have you ever had to leave an apartment, shelter program, or other place you were staying because of your physical health?  Yes  No  Refused
16. Do you have any chronic health issues with your liver, kidneys, stomach, lungs or heart?  Yes  No  Refused
17. If there was space available in a program that specifically assists people that live with HIV or AIDS, would that be of interest to you?  Yes  No  Refused
18. Do you have any physical disabilities that would limit the type of housing you could access, or would make it hard to live independently because you'd need help?  Yes  No  Refused
19. When you are sick or not feeling well, do you avoid getting help?  Yes  No  Refused
20. *FOR FEMALE RESPONDENTS ONLY:*  
Are you currently pregnant?  Yes  No  N/A OR Refused
21. Has your drinking or drug use led you to being kicked out of an apartment or program where you were staying in the past?  Yes  No  Refused
22. Will drinking or drug use make it difficult for you to stay housed or afford housing?  Yes  No  Refused
23. Have you ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of:
- a) A mental health issue or concern?  Yes  No  Refused
- b) A past head injury?  Yes  No  Refused
- c) A learning disability, developmental disability, or other impairment?  Yes  No  Refused
24. Do you have any mental health or brain issues that would make it hard for you to live independently because you'd need help?  Yes  No  Refused
25. Are there any medications that a doctor said you should be taking that, for whatever reason, you are not taking?  Yes  No  Refused
26. Are there any medications like painkillers that you don't take the way the doctor prescribed or where you sell the medication?  Yes  No  Refused
27. Has your current period of homelessness been caused by an experience of emotional, physical, psychological, sexual, or other type of abuse, or by any other trauma you have experienced?  Yes  No  Refused