ANCHORAGE COALITION TO END HOMELESSNESS

Coordinated Entry Transitional Aged Youth (TAY) Assessment

This packet should be used for TAY clients, aged 18-24. Each TAY, even if in the same household/presenting as a couple, will need to complete their own packet/assessment.

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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 Institute for Community Alliance website: https://icalliances.org/alaska-privacy-governance/

Check Age/Household Type.

Please remember that this packet is meant for people 24 years of age or younger. If the client you are serving is older than 24, please complete the Adult Assessment Packet. If the household you are serving includes a minor dependent or if a household member is pregnant, please complete the Family Assessment Packet.

All TAY Must Be Assessed Separately

When completing a Transitional Aged Youth Assessment, please remember that all household members over the age of 18 must receive their own assessment and entry into Coordinated Entry. Adult/TAY couples or families comprised only of legal adults may be housed together, however, they must be assessed separately and put into HMIS as individuals of the household. 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 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 put in HMIS as an "interim review".

II. INTRODUCTORY PARAGRAPH

Instructions: *Please read this introductory paragraph to the client before every assessment. Please emphasize* ***highlighted/bold*** *sections with the client.*

Hello. I'm here to talk to you about your housing and service needs. The purpose of this assessment is to identify what services in town will best help you, let community providers identify gaps in our current social service system, and 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, your current health, substance use, legal involvement, financial stability and other areas related to housing. **The answers you provide in this assessment will not qualify or disqualify you 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 and 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 _____

Email: _____

Secondary Contact: _____

Secondary Contact Number: _____

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.

Gender:		**Ethnicity:**	
☐ Female	☐ Gender Nonconforming	☐ Non -Hispanic/Non-Latino	☐ Client Doesn't Know
☐ Male	☐ Client Doesn't Know	☐ Hispanic/ Latino	☐ Client Refused
☐ Trans (Male to Female)	☐ Client Refused		
☐ Trans (Female to Male)			

Primary Race:		**Secondary Race (Optional):**	
☐American Indian/Alaska Native	☐Client Doesn't Know	☐American Indian/Alaska Native	☐Client Refused
☐Asian	☐Client Refused	☐Asian	☐Client Doesn't Know
☐Black/African American		☐Black/African American	
☐Native Hawai'ian/Pacific Islander		☐Native Hawai'ian/Pacific Islander	
☐White		☐White	

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.

DISABILITY DETERMINATION

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

Please indicate all types of disability below:

Disability Type	Disability Determination	*IF YES:* Is Condition Expected to be Long-Term and Impede ability to Live Independently?
Alcohol Abuse	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused	☐ Yes ☐ No
Both Alcohol & Drug Abuse	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused	☐ Yes ☐ No
Chronic Health Condition	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused	☐ Yes ☐ No
Developmental	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused	☐ Yes ☐ No
Drug Abuse	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused	☐ Yes ☐ No
HIV/AIDS	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused	N/A
Mental Health Problem	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused	☐ Yes ☐ No
Physical	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused	☐ Yes ☐ 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 ___/___/_____
☐ Yes ☐ No ☐ Client doesn't know ☐ Refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Refused	**End Date** ___/___/_____

Alaska Native Corporation Affiliation			
Primary Alaska Native Regional Corporation		**Secondary Alaska Native Regional Corporation**	
☐ Ahtna Corporations	☐ Goldbelt Corporation	☐ Ahtna Corporations	☐ Goldbelt Corporation
☐ Aleut Corporation	☐ Koniag Incorporated	☐ Aleut Corporation	☐ Koniag Incorporated
☐ Arctic Slope Regional	☐ NANA Regional	☐ Arctic Slope Regional	☐ NANA Regional
☐ Bering Straits	☐ Sealaska	☐ Bering Straits	☐ Sealaska
☐ Bristol Bay	☐ 13th Regional Corporation	☐ Bristol Bay	☐ 13th Regional Corporation
☐ Calista Corporation	☐ Client Doesn't Know	☐ Calista Corporation	☐ Client Doesn't Know
☐ Chugach Alaska	☐ Client Refused	☐ Chugach Alaska	☐ Client Refused
☐ Cook Inlet Regional	☐ Not Affiliated	☐ Cook Inlet Regional	☐ Not Affiliated
☐ Doyon		☐ Doyon	

Alaska Native Corporation Optional Key		
Ahtna Corporation	Chugach Alaska Corporation	Sealaska
Aleut Corporation	Cook Inlet Regional Corporation	13th Regional Corporation
Arctic Slope Regional Corporation	Doyon Limited Corporation	Client Doesn't Know
Bering Straits Native Corporation	Goldbelt Corporation	Client Refused
Bristol Bay Native Corporation	Koniag Incorporated	Not Affiliated
Calista Corporation	NANA Regional Corporation	

PRIOR LIVING SITUATION

Section I – Where did you sleep last night?

SELECT ONLY ONE OPTION FROM ONE OF THE HIGHLIGHTED CATEGORIES *(1, 2, or 3)* below. *For example, if the client was in a "Place not meant for habitation", select that from the Homeless Situation category and continue complete Sections II through IV.*

1. Homeless Situation

☐ Place not meant for habitation (e.g. a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)
☐ Emergency shelter, including hotel or motel **paid for with emergency shelter voucher**
☐ ~~Safe Haven~~ (not currently available in AK)

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

☐ Residential project or halfway house with no homeless criteria
☐ Hotel or motel paid for **without** emergency shelter voucher
☐ Transitional housing for homeless persons (including homeless youth)
☐ Host home (non-crisis)
☐ Staying or living in a friend's room, apartment or house
☐ Staying or living in a family member's room, apartment or house
☐ Rental by client, with GPD TIP subsidy
☐ Rental by client, with VASH subsidy
☐ Permanent housing for formerly homeless persons
☐ Rental by client, with RRH or equivalent subsidy
☐ Rental by client, with Housing Choice Voucher (HCV) (tenant or project based)
☐ Rental by client in a public housing unit
☐ Rental by client, no ongoing housing subsidy
☐ Rental by client, with other ongoing housing subsidy
☐ Owned by client, with ongoing housing subsidy
☐ Owned by client, no ongoing housing subsidy

4. Other

☐ Other
☐ Worker unable to determine
☐ Client doesn't know
☐ Client refused

5. If "Other", Specify:

_____

Section II

Please complete all remaining sections:

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

- ☐ One night or less
- ☐ Two to six nights
- ☐ One week or more, but less than one month
- ☐ One month or more, but less than 90 days
- ☐ 90 days or more, but less than one year
- ☐ One year or longer
- ☐ Client doesn't know
- ☐ Client refused

Approximate date most recent episode of homelessness started: _____/_____/_____

Instructions: ** 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 (12 – 36 months)

CURRENT LIVING SITUATION

Location details:_____

Is client going to have leave their living situation within 14 days?

☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused ☐ Data not collected

If "Yes" to "Is client going to have leave their living situation within 14 days?" answer the following questions:

Has a subsequent residence been identified?

☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused ☐ Data not collected

Does individual or family have resources or support networks to obtain other permanent housing?

☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused ☐ Data not collected

Has the client had a lease or ownership interest in a permanent housing unit in the last 60 days?

☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused ☐ Data not collected

Has the client moved 2 or more times in the last 60 days?

☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused ☐ Data not collected

INCOME

Monthly Income Amount (CE Specific): _____

DOMESTIC VIOLENCE – ADULT HOUSEHOLD MEMBERS ONLY

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

If yes, please answer both questions below:

When did this experience occur?
☐ Within last 3 months ☐ 3 – 6 months ago ☐ 6 months ☐ 6 – 12 months ago ☐ 1 year ☐ More than a year ago
☐ Client doesn't know ☐ Refused ☐ Data not collected

Are you currently fleeing domestic violence?
☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused ☐ Data not collected

COORDINATED ENTRY ASSESSMENT

Assessment Location: _____

Assessment Type:
☐ Phone ☐ Virtual ☐ In Person

Assessment Level:
☐ Crisis Needs Assessment ☐ Housing Needs Assessment

Prioritization Status:
☐ Placed on Prioritization List ☐ Not Placed on Prioritization List