ANCHORAGE COALITION TO END HOMELESSNESS

Coordinated Entry Families 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 Alliances website: https://icalliances.org/alaska-privacy-governance/.

Check Age/Household Type

Please remember that this packet is meant for households with minor dependents or households in which a member is pregnant. If the household with whom you are currently working does not have a minor/no member is pregnant, please choose the appropriate assessment to be completed: Adult (25 years or older), Transitional Aged Youth (18-24).

One Assessment per Household

When completing a Family Assessment, please remember that only one packet/assessment needs to be completed. Different amounts of information may be required for each household member, depending on the member's age and their relationship to the head of household. Please make sure to note the specific instructions throughout this packet that identifies which information is needed on all family members vs. which information is only needed for those household members who are 18+.

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 (open entry with no exit) 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

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: _____

HEAD OF HOUSEHOLD INFORMATION:

Demographic 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 for all adults in the household.
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.

HMIS DATA ELEMENTS – ADDITIONAL HOUSEHOLD MEMBERS

Please complete for all additional household members. If necessary add a second chart for additional household members.

Name, DOB, SSN	**Gender** (pick one)	**Race** (Pick up to two)	**Ethnicity** (pick one)	**Relation to HoH** (pick one)
N: _____/_______/_________ _______ - ____ - ______	☐ Female ☐ Trans (M to F) ☐ Male ☐ Trans (F to M) ☐ Refused ☐ Does not Know ☐ Gender Nonconforming	☐ AI/AN ☐White ☐Asian ☐ Does not Know ☐ Black/AA ☐ Refused ☐Native Hawaiian/Pacific Islander	☐ Hispanic/ Latino ☐ Non -Hispanic/Non-Latino ☐ Does not Know ☐ Refused	☐ Spouse/Partner ☐ Child of HoH ☐ Other Relation ☐ Non-Relation
N: _____/_______/_________ _______ - ____ - ______	☐ Female ☐ Trans (M to F) ☐ Male ☐ Trans (F to M) ☐ Refused ☐ Does not Know ☐ Gender Nonconforming	☐ AI/AN ☐White ☐Asian ☐ Does not Know ☐ Black/AA ☐ Refused ☐Native Hawaiian/Pacific Islander	☐ Hispanic/ Latino ☐ Non -Hispanic/Non-Latino ☐ Does not Know ☐ Refused	☐ Spouse/Partner ☐ Child of HoH ☐ Other Relation ☐ Non-Relation
N: _____/_______/_________ _______ - ____ - ______	☐ Female ☐ Trans (M to F) ☐ Male ☐ Trans (F to M) ☐ Refused ☐ Does not Know ☐ Gender Nonconforming	☐ AI/AN ☐White ☐Asian ☐ Does not Know ☐ Black/AA ☐ Refused ☐Native Hawaiian/Pacific Islander	☐ Hispanic/ Latino ☐ Non -Hispanic/Non-Latino ☐ Does not Know ☐ Refused	☐ Spouse/Partner ☐ Child of HoH ☐ Other Relation ☐ Non-Relation
N: _____/_______/_________ _______ - ____ - ______	☐ Female ☐ Trans (M to F) ☐ Male ☐ Trans (F to M) ☐ Refused ☐ Does not Know ☐ Gender Nonconforming	☐ AI/AN ☐White ☐Asian ☐ Does not Know ☐ Black/AA ☐ Refused ☐Native Hawaiian/Pacific Islander	☐ Hispanic/ Latino ☐ Non -Hispanic/Non-Latino ☐ Does not Know ☐ Refused	☐ Spouse/Partner ☐ Child of HoH ☐ Other Relation ☐ Non-Relation
N: _____/_______/_________	☐ Female ☐ Trans (M to F) ☐ Male ☐ Trans (F to M) ☐ Refused ☐ Does not Know ☐ Gender Nonconforming	☐ AI/AN ☐White ☐Asian ☐ Does not Know ☐ Black/AA ☐ Refused ☐Native Hawaiian/Pacific Islander	☐ Hispanic/ Latino ☐ Non -Hispanic/Non-Latino ☐ Does not Know ☐ Refused	☐ Spouse/Partner ☐ Child of HoH ☐ Other Relation ☐ Spouse/Partner
LEGEND:	S AA = African American; AI = American Indian; AN= Alaska Native; HoH = Head of Household; Trans (M to F) = Transgender Male to Female; Trans (F to M) = Transgender Female to Male VA = Veteran Affairs			

DISABILITY DETERMINATION – ALL HOUSEHOLD MEMBERS

Instructions: *Please complete the disability determination charts below for every member in the household. Add a supplemental chart for additional household members as necessary.*

Household Member Name	Disability
	☐ 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
	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused

Instructions: *Complete additional disability determination chart below for every household member who answered "yes" above.* ***Remember****: When entering this data into HMIS, those who answered "no", "client doesn't know", or "refused" will need this chart updated accordingly.*

Name: _____

Disability Type	Disability Determination	*IF YES:* Condition Going to be Long-Term?
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	☐ Yes ☐ No
Mental Health Problem	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused	☐ Yes ☐ No
Physical	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused	☐ Yes ☐ No

Name:_____

Disability Type	Disability Determination	*IF YES:* Condition Going to be Long-Term?
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	☐ Yes ☐ No
Mental Health Problem	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused	☐ Yes ☐ No
Physical	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused	☐ Yes ☐ No

Alaska Mental Health Beneficiary Information

Instructions: *Please collect this information for all household members. If there are more than 4 household members, please print another copy of this chart to account for all members.*

Category	Name	Determination
Alzheimer's Disease and Related Dementias	1.	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused
	2.	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused
	3.	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused
	4.	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused
Chronic Alcoholism or other Substance Use Disorder	1.	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused
	2.	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused
	3.	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused
	4.	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused
Intellectual or Developmental Disabilities	1.	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused
	2.	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused
	3.	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused
	4.	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused
Mental Illness	1.	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused
	2.	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused
	3.	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused
	4.	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused
Traumatic Brain Injuries	1.	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused
	2.	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused
	3.	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused
	4.	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused

Alaska Native Corporation Affiliation – ADULT HOUSEHOLD MEMBERS ONLY		
Instructions: *Please complete the chart below for each household member. Please only use options as provided in the key provided. For those who are not Alaska Native, please use "Not Affiliated."*		
Household Member Name	**Primary Alaska Native Regional Corporation**	**Secondary Alaska Native Regional Corporation** (Optional)

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	

Instructions: From this point forward data will be collected on ***adults in the household only***. Data collection for minors is now complete.

PRIOR LIVING SITUATION – ADULT HOUSEHOLD MEMBERS ONLY

Instructions: *Complete this section for every adult in the household. Print additional charts as necessary. If all adults in the household have been together consistently and the answers to the questions below are the exact same, complete this chart once and input the data into each adult member's HMIS Coordinated Entry HMIS entry.*

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 (HEAD OF HOUSEHOLD AND ADULTS ONLY)

Location details:____

Is client going to have leave their living situation within 14 days?
☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused ☐ Data not collected

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

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

Instructions: *Please complete income questions for each adult in the household. Include room for additional adults as necessary*

Adult Household Member Name	Monthly Income Amount

DOMESTIC VIOLENCE – ADULT HOUSEHOLD MEMBERS ONLY

Is any adult member of the household a victim/survivor of domestic violence? ☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused
Please complete the chart below for each member who answered "yes" to the above.

Name of Adult Household Member	When Did this Occur?	Are you currently fleeing domestic violence?
	☐ Within last 3 months ☐ 3 – 6 months ago ☐ 6 months ☐ 6 – 12 months ago ☐ 1 year ☐ More than a year ago	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused
	☐ Within last 3 months ☐ 3 – 6 months ago ☐ 6 months ☐ 6 – 12 months ago ☐ 1 year ☐ More than a year ago	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused
	☐ Within last 3 months ☐ 3 – 6 months ago ☐ 6 months ☐ 6 – 12 months ago ☐ 1 year ☐ More than a year ago	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused
	☐ Within last 3 months ☐ 3 – 6 months ago ☐ 6 months ☐ 6 – 12 months ago ☐ 1 year ☐ More than a year ago	☐ Yes ☐ No ☐ Client Doesn't Know ☐Refused

COORDINATED ENTRY ASSESSMENT – ADULT HOUSEHOLD MEMBERS ONLY

Name of Adult Household Member	Date of Assessment	Assessment Location	Assessment Type	Assessment Level	Prioritization Status
			☐ Phone ☐ Virtual ☐ In Person	☐ Crisis Needs Assessment ☐ Housing Needs Assessment	☐ Placed on Prioritization List ☐ Not Placed on Prioritization List
			☐ Phone ☐ Virtual ☐ In Person	☐ Crisis Needs Assessment ☐ Housing Needs Assessment	☐ Placed on Prioritization List ☐ Not Placed on Prioritization List
			☐ Phone ☐ Virtual ☐ In Person	☐ Crisis Needs Assessment ☐ Housing Needs Assessment	☐ Placed on Prioritization List ☐ Not Placed on Prioritization List
			☐ Phone ☐ Virtual ☐ In Person	☐ Crisis Needs Assessment ☐ Housing Needs Assessment	☐ Placed on Prioritization List ☐ Not Placed on Prioritization List