

SMAC and Ramsey Coordinated Entry Assessment

Client Name: _____ **HMIS ID:** _____

ASSESSOR INSTRUCTIONS: Please read or paraphrase the following to the client.

I work for (name of your agency) and we are going to complete a Step 2 assessment. This will give me a better idea of what your housing and service needs are. If you say it is ok to continue, I will ask you questions about your health and housing. If you do not understand a question, please say so. I can help explain what is being asked. Some of the questions may be personal, but you will only need to answer yes/no. I don't need specific details.

The questions are not meant to judge you, but to assess your needs at this time. If you feel uncomfortable you can take a break or skip a question. If you do not answer a question, no one will be upset with you. But, this information is important to help decide if you are eligible for service, so skipped or inaccurate answers may affect your eligibility. This information will help determine your eligibility and connect you to housing/services.

At any time, you can ask that the information you are giving me not be shared. If at any time you are unhappy with the assessment process and/or resulting score or you feel you were treated unfairly, you have the right to let us know.

You can submit a grievance to SMAC or Ramsey, and the grievance will be looked at by a team working with the Coordinated Entry process. Do you want to continue?

SECTION 1: Assessor Information

Date of Assessment	Location Completed	Assessor's Name	Assessor's Organization	Assessor's Phone	Assessor's Email

SECTION 2: Client Contact Information

Phone number where you can be reached or a message can be left:	
Email where you can be reached or where a message can be sent:	
Can we leave a confidential voicemail or text for you at the phone number provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Secondary Contact Information

Name:	Name:
Phone:	Phone:
Email:	Email:
Relationship:	Relationship:
Can we speak with the contacts you listed to leave information for you?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 3: Background Information

HMIS ROI Signed? <input type="checkbox"/> Yes <input type="checkbox"/> No – Agency ROI Needed
Client Relationship to Head of Household:
Social Security Number:
Client Date of Birth:

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Client Name: _____

<p>Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender MTF <input type="checkbox"/> Transgender FTM <input type="checkbox"/> Gender non-conforming <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused Preferred Gender Pronouns: _____</p>
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Race:	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused
Ethnicity:	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused
Are you Native American?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, of which tribe are you an enrolled member? _____

County of Primary (Current) Residence: _____ **Client Location (CoC):** _____

Did you serve on Active Duty, or in the National Guard or Reserves? Yes No

If yes, answer the Veteran Status questions below. If no, you may skip them.

For approximately how many months did you serve?	
Did you enter Active Duty before 9/7/1980?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Guard or Reserve: Were you ever called into active duty as a member of the National Guard or as a Reservist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What kind of discharge did you have?	
Has Client been referred to the Homeless Veteran Registry ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has this client record been checked against the VA Squares database?	<input type="checkbox"/> Yes <input type="checkbox"/> No
SQUARES:	<input type="checkbox"/> No, could not confirm veteran status <input type="checkbox"/> Yes, confirmed veteran <input type="checkbox"/> Did not check SQUARES

Currently in school or working on any degree?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you willing and able to work?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 4: Household Composition

Household Type	<input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Youth – Single <input type="checkbox"/> Youth – Family
Household Size: Total # of Persons	
Household Size: Total # of Children (17 and under):	
Household Size: Total # of Adults (18+)	
Are you pregnant?	
If yes, Projected Due Date	

Additional Household Members – Additional space in Notes if needed.

Relationship to HoH	Race	Hispanic/Latino?	Gender	Date of Birth	School/Daycare (Ramsey Co. Only)
		<input type="checkbox"/> Yes <input type="checkbox"/> No			
		<input type="checkbox"/> Yes <input type="checkbox"/> No			
		<input type="checkbox"/> Yes <input type="checkbox"/> No			

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Client Name: _____

Is there anyone else you plan to live with? Yes No

If yes, please explain: _____

SECTION 5: Income

Income from Any Source?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, Total Household Monthly Income:	
If \$0 income, will you have income in the next month?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is the expected amount of that income?	

HoH Income Chart

Source of Income – HoH	Monthly Amount

Other Household Members Income Chart

Source of Income	Monthly Amount

Non-Cash benefit from any source? Yes No
 If yes, from which county are you receiving non-cash benefits? _____

HoH Non-Cash Benefit chart

Source of Non-Cash Benefit – HoH Only

SECTION 6: Domestic Violence/Trafficking

Script: Some housing resources are targeted for people who have experienced domestic or sexual violence – past or present. These next questions are about that. They are mostly yes/no questions and don't need details.

Is anyone CURRENTLY trying to harm you, control your daily activities, resources, and/or documents, or force you to do things you don't want to do?	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the past, has anyone ever tried to harm you, control you, or force you in those ways?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been involved in dancing, stripping, prostitution, massage, porn, survival sex, or trafficking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(If applicable) How long have you been thinking about leaving? (To establish length of time homeless – Please enter the date they started thinking about leaving)	___/___/___

Script: Thank you for sharing with me. There are advocacy resources available for both people who are currently experiencing violence as well as those who experienced it in the past. You deserve to be safe and have support around you. I can provide you with contact information for an advocate or we can call them right now. (Day 1 number is 866-223-1111)

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SECTION 7: Health Information

NOTE: Please include the names of any relevant service providers in Section 11 of this CES Assessment.

Does client have a disability of long duration?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, have you been told by a medical professional that you have a severe mental illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No

HoH Disability Chart

Disability Type (Mental Health, Alcohol Abuse, Drug Abuse, Both Alcohol and Drug Abuse, Physical, Developmental, HIV/AIDS, Chronic Health Condition)	Is it documented?	Expected to be of long-continued and infinite duration and substantially impairs ability to live independently?

Other Household Members Disability Chart

Relationship to HoH	Disability Type	Date of Diagnosis	Does your disability limit your ability to live independently?	Is the disability documented?

What accommodation do you require due to health or disability? _____

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Housing Status:	<input type="checkbox"/> Category 1: HUD Homeless <input type="checkbox"/> Category 2: At imminent risk of losing housing <input type="checkbox"/> Category 4: Fleeing Domestic Violence
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CoC Note: Category 3 is not used and was omitted intentionally

Clients age 16 - 22 only: Is there another safe place you could stay, including staying with someone else (friend, neighbor, family)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Barriers to Housing

Do you owe money to any past landlords?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you owe any money to PHA?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any past due utilities payments?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes to any of these, please include details here:	

SECTION 9: Legal History

Note: Please add any current case worker information to Section 11: Provider Involvement.

Do you have a legal/criminal history? Yes No

If yes, please complete this chart.

Relationship to HoH	Offense Type (Drug, Arson, Sex Offense, Violent Crime, Non-Violent Crime)	Classification (Felony, Misdemeanor)	Number of Offenses	Date of Most Recent Conviction	Active warrant or any open criminal case?	If sex offense, registered sex offender?
				__/__/__		
				__/__/__		
				__/__/__		

SECTION 10: Housing Preferences

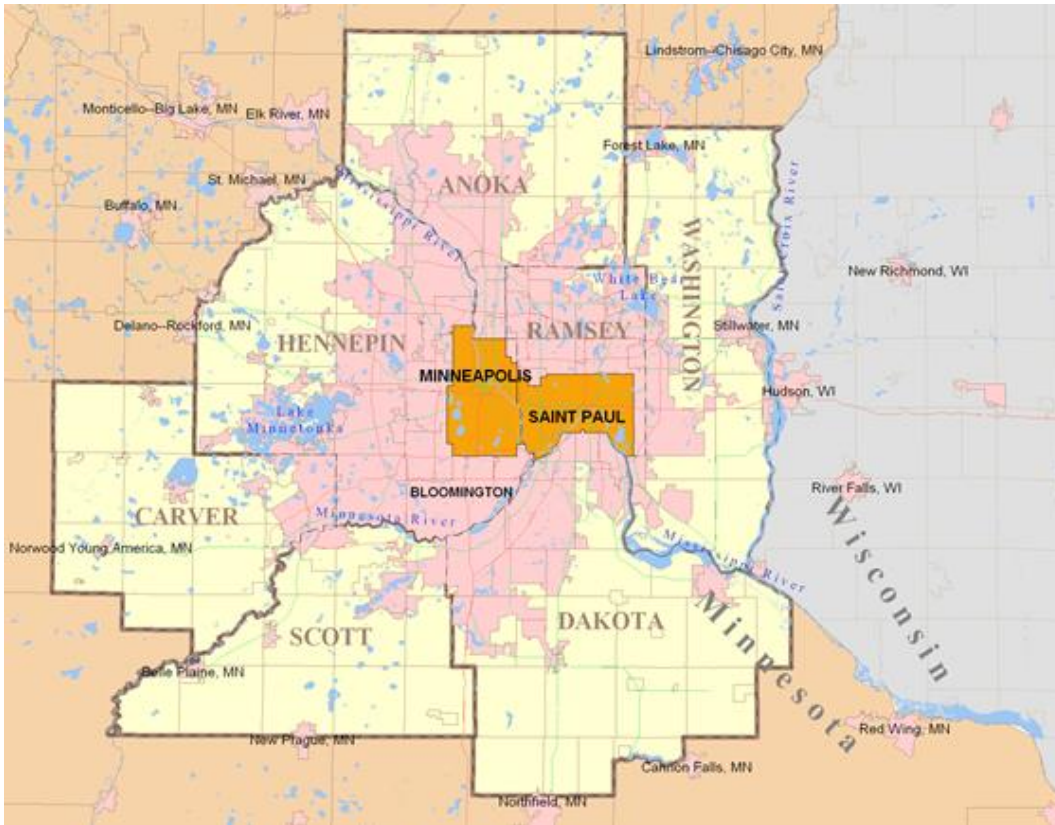
Are you willing to live anywhere in the 7 county metro area? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please rank up to 5 counties that you would prefer to live in.	
Client choice 1:	
Client choice 2:	
Client choice 3:	
Client choice 4:	
Client choice 5:	

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Client Name: _____

Please indicate CoC based on client preferences. If the client identifies a CoC outside of their current residence, notify the priority list manager.

SMAC Ramsey Hennepin Other: _____



Specific Services: Are you willing to consider or are you interested in programs that...	
Utilize Housing Support (formerly known as GRH) funding to cover the cost of housing and services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Offer shared housing or SROs (ie you have your own bedroom but may share kitchen, living, bathroom)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have a front desk that helps monitor visitors?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Provide a sober, recovery-oriented community (may require UA at intake and randomly once housed)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Target Populations

Directions: Let client know that some housing programs serve people from specific cultural backgrounds or with particular life experiences. Some of these are covered elsewhere in the assessment, but this section allows the client to indicate if they would be open to housing programs that serve that specific group.

Tell client: I'm going to read through the list of populations that may be served by specialty programs. For each one, if you identify as being a part of that population, tell me if you would be open to housing within those targeted programs.

African American/Black	<input type="checkbox"/> Yes <input type="checkbox"/> No	People living with chemical health diagnosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
American Indian	<input type="checkbox"/> Yes <input type="checkbox"/> No	People living with HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Latinx	<input type="checkbox"/> Yes <input type="checkbox"/> No	People living with Severe and Persistent Mental Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No
LGBTQ+ Youth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Survivors of trafficking or sexual exploitation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Multi-Racial Households	<input type="checkbox"/> Yes <input type="checkbox"/> No	Veterans	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 11: Provider Involvement

Directions: Please list all social service providers who client is currently working with. This could be targeted case management or other forms of social services, financial, mental health, vocation, veteran, child protection, etc.

Provider Type	County	Worker Agency	Worker Name	Worker Contact

Are you working with ACT, CTI, TCM mental health worker?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Were you ever in foster care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently in foster care or a ward of the state?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes to either, did you enter foster care after the age of 16?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Additional Notes