Referral for PSH & Case Management Services for the Chronically Homeless

To be referred for Supportive Housing Programs, clients must be chronically homeless. HUD defines chronic homelessness as an individual or family with a disabling condition who has been continuously homeless for a year or more or has had at least four episodes of homelessness in the past three years.

Clients Name: **Referral Date:**

Date of Birth: **SS#:**

Clients Phone/location:

Referral Source:

Phone # of Referral Source:

Disabling Condition:

Alcohol/Substance Abuse: ☐ Alcohol ☐ Opiate ☐ Substance Abuse
Mental Disability: ☐ Schizophrenic ☐ Bi-Polar ☐ Depression ☐ other _____
Physical Disability: ☐ Mobility Impairment ☐ TBI ☐ Chronic illness

Major psychosocial or mental health concern:

☐ drug/alcohol abuse ☐ depression/suicide ☐ grief
☐ developmental disability ☐ gang involvement ☐ pregnancy support
☐ eating disorder ☐ physical/sexual abuse ☐ neglect
☐ reactions to chronic illness ☐ self esteem ☐ family/relationship probs.
☐ anxiety/phobia ☐ legal problems ☐ Violent behavior

Other specific concerns:

Current homeless episode and desire for assistance:

Homeless episode: ☐ 6-8 months ☐ 9-11 months ☐ 12+ months ☐ 4x/3 years
Client motivation for assistance: ☐ Highly motivated ☐ semi-Motivated ☐ low motivation
Is the client refusing housing: ☐ Y ☐ N

Pre-Chronically Homeless ☐ Y ☐ N **Chronically Homeless** ☐ Y ☐ N

Single Site Screening

Does client have a history of arson? ☐ Y ☐ N
Is client a registered sex offender? ☐ Y ☐ N
Does client have a recent history of assault? ☐ Y ☐ N
Has client ever resided in single site PSH? ☐ Y ☐ N

PSH Program Referral (To be completed by coordinated entry staff only)

Caz☐ Evergreen☐ Matt Urban☐ Spectrum☐ HOME ☐ Safe Haven☐ Hope Gardens☐ SPOA☐

Please complete this form along with a VI-SPDAT and submit to the Matt Urban Homeless Outreach Department with a Homeless Verification and/or 3 year housing history attached.
Forms can be faxed to (716)855-2110 or emailed to sdiamond@urbanctr.org

Flowchart of HUD's Definition of Chronic Homelessness

Instructions: Begin at the "START HERE" box and then proceed through the flowchart based on the yes or no questions presented. For more information consult 24CFR Parts 91 & 578 and the HUD Exchange (https://www.hudexchange.info/).

START HERE

Does the head of the household have a qualifying disability?

Yes

No

Remember:
- Occasions are separated by a break of at least seven nights

- Stays in institution of fewer than 90 days do not constitute a break

Is the head of household currently residing in one of the following:

- Emergency Shelter
- On the Street/Place not Meant for Human Habitation
- Safe Haven

No

Is the head of household residing in an institutional care facility?

No

The household does not meet the definition of Chronically Homeless

Yes

Has the head of household stayed there for less than 90 days?

No

Yes

Immediately prior to entering the institution, did the head of household reside in one of the following locations:

- Emergency Shelter
- On the Street/Place not Meant for Human Habitation
- Safe Haven

No

Yes

Has the head of household resided one or more of those locations for the last 12 consecutive months?

Yes

1. Household is Chronically Homeless
(12 Consecutive Months)
Documentation Options Explained on the next page.

No

Yes

Has the head of household resided there for the last 12 consecutive months?

Yes

1. Household is Chronically Homeless
(12 Consecutive Months)
Documentation Options Explained on the next page.

No

Has the head of household resided in one more of these destinations:

- Shelter / Street / Safe Haven
- Institution (resided there less than 90 days (and came from streets/shelter/safe haven immediately prior)

For at least 12 months, over the last 3 years (does not need to be consecutive)?

Yes

Is the head of household's stay (of at least 12 months) broken up by at least 3 breaks?

No

The household does not meet the definition of Chronically Homeless

Yes

2. Household is Chronically Homeless
(4+ Occasions totaling 12 months over 3 years)
Documentation Options Explained on the next page.

No

The household does not meet the definition of Chronically Homeless

Documentation Standards for Chronic Homelessness

Instructions: *Based on your navigation of the flowchart on the previous page, locate the appropriate numbered situation on this page and follow the documentation standards noted. This tool summarizes the criteria for the new Chronically Homeless Definition. To review the exact language, please refer to 24 CFR Parts 91 & 578 and the HUD Exchange (https://www.hudexchange.info/homelessness-assistance/resources-for-chronic-homelessness/)*

Situation	Documentation of Homelessness	Documentation of Disability
1. Household is Chronically Homeless (12 Consecutive Months)	☐ HMIS record or record from a comparable database; or ☐ Written observation by an outreach worker of the conditions where the individual was living; or ☐ Written referral by another housing or service provider; or ☐ Where the evidence above is unavailable, there must be a certification by the individual seeking assistance, accompanied by the intake worker's documentation of the living situation and the steps taken to obtain the evidence listed above. If the head of household is currently staying in an institution where they have been for less than 90 days (and were in a shelter/street/safe haven immediately prior) their Institutional Stay can be documented by: ☐ Discharge paperwork or written/oral referral from a social worker or appropriate official of the institutional facility, with start/end dates of client's residence, or ☐ Where the evidence above is unavailable, there must be a certification by the individual seeking assistance, accompanied by the intake worker's documentation of the living situation and the steps taken to obtain the evidence listed above.	Documentation of the head of household's disability, including: ☐ Written verification of the disability from a licensed professional; ☐ Written verification from the Social Security Administration; ☐ The receipt of a disability check; or ☐ Intake staff-recorded observation of disability that, no later than 45 days from the application for assistance, accompanied by supporting evidence.
2. Household is Chronically Homeless (4+ Occasions totaling 12 months over 3 years)* **May include institution stays of <90 days*	☐ HMIS record or record from a comparable database; or ☐ Written observation by an outreach worker of the conditions where the individual was living; or ☐ Written referral by another housing or service provider; or ☐ Discharge paperwork or written/oral referral from a social worker or appropriate official of the institutional facility, with start/end dates of client's residence (for institutional stays of less than 90 days) ☐ Where the evidence above is unavailable, there must be a certification by the individual seeking assistance, accompanied by the intake worker's documentation of the living situation and the steps taken to obtain the evidence listed above. ** Each separate occasion MUST be documented (minimum of 3 breaks). 100% of the breaks can be documented by self- report.*	Documentation of the head of household's disability, including: ☐ Written verification of the disability from a licensed professional; ☐ Written verification from the Social Security Administration; ☐ The receipt of a disability check; or ☐ Intake staff-recorded observation of disability that, no later than 45 days from the application for assistance, accompanied by supporting evidence.

Important Notes:

- *Each individual occasion needs to be fully documented.*
- *Breaks can be documented by self-report.*
- *For each Project:*
  - *100% of households served can use self-certification for 3 months of their 12 months,*
  - *75% of households served need to use 3rd Party documentation for 9 months of their 12 months, and*
  - *25% of households served can use self-certification as documentation for any and all months.*

Administration

Interviewer's Name	**Agency**	☐ Team ☐ Staff ☐ Volunteer
_____	_____	
Survey Date	**Survey Time**	**Survey Location**
DD/MM/YYYY ____/____/_____	__ __ : __ __ AM/PM	_____

Opening Script

Every assessor in your community regardless of organization completing the VI-SPDAT should use the same introductory script. In that script you should highlight the following information:

- the name of the assessor and their affiliation (organization that employs them, volunteer as part of a Point in Time Count, etc.)
- the purpose of the VI-SPDAT being completed
- that it usually takes less than 7 minutes to complete
- that only "Yes," "No," or one-word answers are being sought
- that any question can be skipped or refused
- where the information is going to be stored
- that if the participant does not understand a question or the assessor does not understand the question that clarification can be provided
- the importance of relaying accurate information to the assessor and not feeling that there is a correct or preferred answer that they need to provide, nor information they need to conceal

Basic Information

First Name	**Nickname**	**Last Name**
_____	_____	_____

In what language do you feel best able to express yourself? _____

Date of Birth	**Age**	**Social Security Number**	**Consent to participate**	
DD/MM/YYYY ____/____/_____	_____	_____	☐ Yes	☐ No

IF THE PERSON IS 60 YEARS OF AGE OR OLDER, THEN SCORE 1.

SCORE:

1 (800) 355-0420 info@orgcode.com www.orgcode.com

A. History of Housing and Homelessness

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

☐ Shelters
☐ Transitional Housing
☐ Safe Haven
☐ **Outdoors**
☐ **Other (specify):** _____
☐ **Refused**

IF THE PERSON ANSWERS ANYTHING OTHER THAN "SHELTER", "TRANSITIONAL HOUSING", OR "SAFE HAVEN", THEN SCORE 1.	**SCORE:**

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

IF THE PERSON HAS EXPERIENCED 1 OR MORE CONSECUTIVE YEARS OF HOMELESSNESS, AND/OR 4+ EPISODES OF HOMELESSNESS, THEN SCORE 1.	**SCORE:**

B. Risks

4. In the past six months, how many times have you...

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 a short-term stay like the drunk tank, a longer stay for a more serious offence, or anything in between? ____ ☐ Refused

IF THE TOTAL NUMBER OF INTERACTIONS EQUALS 4 OR MORE, THEN SCORE 1 FOR **EMERGENCY SERVICE USE.**	**SCORE:**

5. Have you been attacked or beaten up since you've become homeless? ☐ **Y** ☐ N ☐ Refused

6. Have you threatened to or tried to harm yourself or anyone else in the last year? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **RISK OF HARM.**	**SCORE:**

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? ☐ **Y** ☐ N ☐ Refused

IF "YES," THEN SCORE 1 FOR **LEGAL ISSUES.** **SCORE:**

8. Does anybody force or trick you to do things that you do not want to do? ☐ **Y** ☐ N ☐ 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? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **RISK OF EXPLOITATION.** **SCORE:**

C. Socialization & Daily Functioning

10. Is there any person, past landlord, business, bookie, dealer, or government group like the IRS that thinks you owe them money? ☐ **Y** ☐ N ☐ 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? ☐ Y ☐ **N** ☐ Refused

IF "YES" TO QUESTION 10 OR "NO" TO QUESTION 11, THEN SCORE 1 FOR **MONEY MANAGEMENT.** **SCORE:**

12. Do you have planned activities, other than just surviving, that make you feel happy and fulfilled? ☐ Y ☐ **N** ☐ Refused

IF "NO," THEN SCORE 1 FOR **MEANINGFUL DAILY ACTIVITY.** **SCORE:**

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? ☐ Y ☐ **N** ☐ Refused

IF "NO," THEN SCORE 1 FOR **SELF-CARE.** **SCORE:**

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? ☐ **Y** ☐ N ☐ Refused

IF "YES," THEN SCORE 1 FOR **SOCIAL RELATIONSHIPS.** **SCORE:**

D. Wellness

15. Have you ever had to leave an apartment, shelter program, or other place you were staying because of your physical health?	☐ **Y**	☐ N	☐ Refused
16. Do you have any chronic health issues with your liver, kidneys, stomach, lungs or heart?	☐ **Y**	☐ N	☐ 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?	☐ **Y**	☐ N	☐ 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?	☐ **Y**	☐ N	☐ Refused
19. When you are sick or not feeling well, do you avoid getting help?	☐ **Y**	☐ N	☐ Refused
20. *FOR FEMALE RESPONDENTS ONLY:* Are you currently pregnant?	☐ **Y**	☐ N	☐ N/A or Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **PHYSICAL HEALTH.** **SCORE:**

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?	☐ **Y**	☐ N	☐ Refused
22. Will drinking or drug use make it difficult for you to stay housed or afford your housing?	☐ **Y**	☐ N	☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **SUBSTANCE USE.** **SCORE:**

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?	☐ **Y**	☐ N	☐ Refused
b) A past head injury?	☐ **Y**	☐ N	☐ Refused
c) A learning disability, developmental disability, or other impairment?	☐ **Y**	☐ N	☐ 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?	☐ **Y**	☐ N	☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **MENTAL HEALTH.** **SCORE:**

IF THE RESPONENT SCORED 1 FOR **PHYSICAL HEALTH** AND 1 FOR **SUBSTANCE USE** AND 1 FOR **MENTAL HEALTH**, SCORE 1 FOR **TRI-MORBIDITY**. **SCORE:**

25. Are there any medications that a doctor said you should be taking that, for whatever reason, you are not taking? ☐ **Y** ☐ N ☐ Refused

26. Are there any medications like painkillers that you don't take the way the doctor prescribed or where you sell the medication? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR **MEDICATIONS.**	**SCORE:**

27. *YES OR NO:* 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? ☐ **Y** ☐ N ☐ Refused

IF "YES", SCORE 1 FOR **ABUSE AND TRAUMA.**	**SCORE:**

Scoring Summary

DOMAIN	SUBTOTAL
PRE-SURVEY	/1
A. HISTORY OF HOUSING & HOMELESSNESS	/2
B. RISKS	/4
C. SOCIALIZATION & DAILY FUNCTIONS	/4
D. WELLNESS	/6
GRAND TOTAL:	/17

RESULTS	
Score:	**Recommendation:**
0-3:	no housing intervention
4-7:	an assessment for Rapid Re-Housing
8+:	an assessment for Permanent Supportive Housing/Housing First

Follow-Up Questions

On a regular day, where is it easiest to find you and what time of day is easiest to do so?	place: _____ time: ___ : ____ or Morning/Afternoon/Evening/Night
Is there a phone number and/or email where someone can safely get in touch with you or leave you a message?	phone: (____) _____ - _____ email: _____
Ok, now I'd like to take your picture so that it is easier to find you and confirm your identity in the future. May I do so?	☐ Yes ☐ No ☐ Refused

Communities are encouraged to think of additional questions that may be relevant to the programs being operated or your specific local context. This may include questions related to:

- military service and nature of discharge
- ageing out of care
- mobility issues
- legal status in country
- income and source of it
- current restrictions on where a person can legally reside
- children that may reside with the adult at some point in the future
- safety planning

Erie County Department of Mental Health
Permission to Use and Disclose Confidential Information

This form is designed to be used by organizations that collaborate with one another in planning, coordinating, and delivering services to persons diagnosed with mental disabilities. It permits use, disclosure, and re-disclosure of confidential information for the purposes of care coordination, delivery of services, payment for services and health care operations. This form complies with the requirements of § 33.13 of the New York State Mental Hygiene Law, federal alcohol and drug record privacy regulations (42 CFR Part 2), and federal law governing privacy of education records (FERPA) (20 USC 1232g). It is not for use for HIV-AIDS related information. Although it includes many of the elements required by 45 CFR 164.508(c), this form is not an "Authorization" under the federal HIPAA rules. An "Authorization" is not required because use and disclosure of protected health information is for purposes of treatment, payment or health care operations. (See 45 CFR 164.506.)

1. I hereby give permission to use and disclose health, mental health, alcohol and drug, and education records as described below.
2. The person whose information may be used or disclosed is:

   Name: _____. Date of Birth: _____
3. The information that may be used or disclosed includes (check all that apply):

   ☐ Mental health records

   ☐ Alcohol/Drug Records

   ☐ School or Education Records

   ☐ Health records

   ☒ All of the records listed above

4. This information may be disclosed by:

   ☒ Any person or organization that possesses the information to be disclosed

   ☐ The persons or organizations listed in Attachment A

   ☐ The following persons or organizations that provide services to me:

   _____ _____

   _____ _____

5. This information may be disclosed to:

   ☒ Any person or organization that needs the information to provide service to the person who is the subject of the record, pay for those services, or engage in quality assurance or other health care operations related to that person.

   ☐ The persons or organizations listed in Attachment A

   ☐ The following persons or organizations:

   _____ _____

   _____ _____

6. The purposes for which this information may be used and disclosed include:

   - Evaluation of eligibility to participate in a program supported by the Erie County Department of Mental Health;
   - Delivery of services, including care coordination and case management;
   - Payment for services; and
   - Health Care Operations such as quality assurance.
   -

7. I understand that New York and federal law prohibits persons that receive mental health, alcohol, or drug abuse, and education records from re-disclosing those records without permission. I also understand that not every organization that may receive a record is required to follow the federal HIPAA rules governing use and disclosure of protected health information. I HEREBY GIVE PERMISSION TO THE PERSONS AND ORGANIZATIONS THAT RECEIVE RECORDS PURSUANT TO THIS AUTHORIZATION TO RE-DISCLOSE THE RECORD AND THE INFORMATION IN THE RECORD TO PERSONS OR ORGANIZATIONS DESCRIBED IN PARAGRAPH 5 FOR THE PURPOSES PERMITTED IN PARAGRAPH 6, BUT FOR NO OTHER PURPOSE.

Erie County Department of Mental Health
Permission to Use and Disclose Confidential Information (con't.)

8. This permission expires (check applicable box):

☐ On _____

☒ Upon the following event: Three months post program completion

9. This permission is limited as follows:

☐ Permission only applies to records for the following time period: _____ to _____

☐ Other limitation: _____

10. I understand that this permission may be revoked. I have received a Notice of Privacy Practices, and understand that if this permission is revoked, it may not be possible to continue to participate in certain programs. I will be informed of that possibility if I wish to revoke this permission. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose records and protected health information as needed to complete work that began because this permission was given.

I am the person whose records will be used or disclosed. I give permission to use and disclose my records as described in this document.

_____ _____

Signature Date

I am the personal representative of the person whose records will be used or disclosed. My relationship to that person is_____ _____. I give permission to use and disclose my records as described in this document.

_____ _____

Signature Date

_____

Print Name

Attachment A

This permission to disclose records applies to the following organizations and people who work at those organizations. These organizations work together to deliver services to residents of Erie County.

Alcohol & Drug Dependency Services
Baker Victory Services
Berkshire Farm
BryLin Hospital
Buffalo Federation of Neighborhood Centers
Catholic Charities
Cazenovia Recovery Services
Child& Adolescent Treatment Services
Community Connections of New York
Community Services for the Developmentally Disabled
Compeer West
EC Department of Mental Health
EC Forensic Mental Health Services
Erie County Medical Center
Gateway – Longview
Heritage Centers
Hillside Children's Center
Horizon Health Services
Housing Options Made Easy, Inc.
Jewish Family Services
Joan A. Male
Kaleida Health
Lake Shore Behavioral Health
TLC Hospital
Living Opportunities of DePaul
Mental Health Association
Mid-Erie Counseling &Treatment Services
Monsignor Carr Institute
New Directions
Niagara Falls Memorial Hospital
Northwest Community Mental Health Center
RedArgyle
Restoration Society, Inc.
Southern Tier Environments for Living
Spectrum Human Services
Suburban Adult Services, Inc.
Suicide Prevention & Crisis Services
Transitional Services, Inc.
University Psychiatric Practice
Western New York Independent Living Project
WNY Children's Psychiatric Center
YWCA of Western New York

Other:
Other