West Central Illinois Continuum of Care Consortium

Coordinated Assessment Policies and Procedures[1]

November 6, 2015

I. Background

A. General

Coordinated Assessment, also known as coordinated entry or coordinated intake, is a system that allows for a coordinated entry into your local homeless services. Coordinated Assessment increases the efficiency of a homeless assistance system by standardizing access to homeless services and coordinating program referrals. As part of the HEARTH regulations that govern Continuum of Care (CoC) and Emergency Solutions Grant (ESG) funding, the U.S. Department of Housing and Urban Development (HUD) requires all CoCs across the United States to implement Coordinated Assessment.

The benefits of centralizing the assessment process include:

- Providing a clearer and more streamlined path to accessing assistance for people who are currently or at imminent risk of experiencing homelessness
- Decreasing the time housing providers spend processing requests for assistance, which increases the resources available for direct service
- Prioritizing scarce housing resources for the most vulnerable
- Improved data collection and quality that supports data-driven decision making based on client-level and system-wide needs

[1] The following Coordinated Assessment documents were used as a starting point and inspiration for creating this document:

- North Carolina Balance of State's (NC BOS) Coordinated Assessment Toolkit, available at: http://www.ncceh.org/bos;
- Portland, Maine CoC Draft Coordinated Assessment Policies and Procedures, 2/13/2015, available at: http://www.portlandmaine.gov/1049/Continuum-of-Care;
- Mecklenburg County, NC Coordinated Assessment Policies and procedures, Developed March 2014, available at: http://charmeck.org/city/charlotte/nbs/housing/housingcoalition/Pages/CoordinatedAssessment.aspx;
- Austin, TX Coordinated Assessment and an Integrated System of Care Coordinated Assessment Workgroup Recommendations, October 14, 2013 report, available at: http://austinecho.org/wp-content/uploads/2013/12/CA_ISoC_steering_committee_recommendations.pdf.

B. Vision Statement

West Central Illinois Continuum of Care 's (WCICCC's) Coordinated Assessment assists to end homelessness by increasing exits to housing, decreasing length of time homeless, and reducing returns to homelessness. Consumers will quickly access appropriate services to address housing crises through a right-sized, well-coordinated agency network.

C. Terms & Definitions

- Provider – Organization that provides services or housing to people experiencing or at-risk of homelessness (e.g. Madonna House located in Quincy, IL)
- Program – A specific set of services or a housing intervention offered by a provider (e.g. ESG Rapid Rehousing program would be one offered by Salvation Army located in Quincy, IL)
- Consumer – Person at-risk of or experiencing homelessness or someone being served by the coordinated assessment process
- Housing Interventions – Housing programs and subsidies; these include transitional housing, rapid re-housing, and permanent supportive housing programs, as well as permanent housing subsidy programs (e.g. housing vouchers)
- Assessment Specialist – Trained employees of a provider that administers the assessment tools to consumers.

D. Target Population

This process is intended to serve people experiencing homelessness and those who believe they are at imminent risk of homelessness. Homelessness will be defined in accordance with the official HUD definition of homelessness. People at imminent risk of homelessness are people who believe they will become homeless, according to the HUD definition, within the next 72 hours (Appendix A). People who think they have a longer period of time before they will become homeless should be referred to other prevention-oriented resources available in the community.

E. Guiding Principles

The WCICCC is a rural continuum and includes eleven counties in West Central Illinois: Adams, Brown, Cass, Hancock, Henderson, McDonough, Morgan, Pike, Schuyler, Scott, and Warren counties. Across the WCICCC, all locally designed and operated coordinated assessment systems will be:

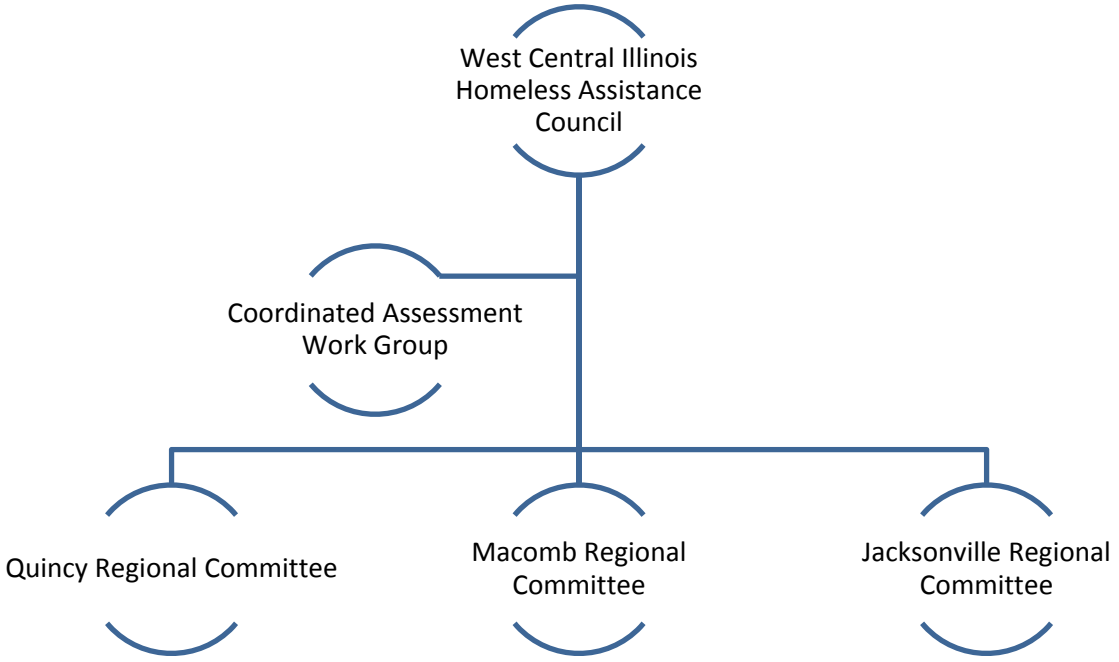
- Sustainable – Resources required to operate the coordinated assessment system are identified and available now and for the foreseeable future

- Flexible – Localization and customization is allowed based on community needs, resources, and services available
- Transparent and accountable – Consumers know what is being done and why, agencies have their program rules on the table, there are clear appeal and grievance processes for both consumers and agencies
- Housing-focused – People experiencing housing crises return to permanent housing within 30 days, in compliance with HEARTH
- Client-focused – System is accessible, leaves no one behind, and accommodates choice/need
- Collaboration-focused – System is operated from broad-based consensus, system linkage responsibilities are managed by partnerships with integrity, and agencies hold each other accountable and exhibit a willingness to cooperate
- Easy to use – System is not cumbersome to agencies, is also accessible and well-known to the community.

II. Governance

A. General Structure

Coordinated Assessment in the WCICCC will be designed and administered at the Regional Committee level with standards and governance provided by the WCICCC's Council (West Central Illinois Homeless Assistance Council) or "IL 519" as designated by HUD. The Council will appoint a standing Coordinated Assessment Workgroup to review, provide feedback on, and ultimately approve coordinated assessment plans written by Regional Committees. The Coordinated Assessment Workgroup will be made up of representatives from across the CoC.



B. Role of Regional Committee

Each Regional Committee will design a local coordinated assessment system within parameters contained in this document. The framework in this document gives Regional Committees a supportive framework to use while building local systems as well as standardized pieces that will be uniform across our CoC – including the 3-part Coordinated Assessment Screening that Regional Committees will use to divert, assess, refer, and case manage households experiencing homelessness.

C. Grievance

As part of the coordinated assessment plan, Regional Committees will create a grievance process for clients and agencies using the system to formally bring their concerns to the Regional Committee. Local grievance procedures will handle the majority of issues. For issues that cannot be resolved at the local level, grievance concerns can be appealed to the Coordinated Assessment Workgroup of the WCICCC Council for resolution. Grievances that reach the Regional Coordinated Assessment Committee will be filed with the Support Entity for record retention.

III. Coordinated Assessment Models

A. Model Overview

Coordinated Assessment in the WCICCC will have standardized elements and yet have flexible design and implementation to meet each Regional Committee's unique needs. Regional Committees will choose one of the following models:

- **Centralized:** Designated agency or agencies within a community will handle intake and referrals

  OR

- **Decentralized:** All agencies will employ the common assessment and referral system for intake

Regional Committees will design a plan for how coordinated assessment referrals will work locally using the three-part Coordinated Assessment Screening, discussed in the next section, and the Regional Committee Plan form. Please see Appendix B for the Coordinated Assessment Workgroup and the Regional Committees they represent. Appendix B also shows each region's plan.

B. Quincy Regional Implementation

According to the 2015 Housing Inventory Count performed in January, there were 19 providers that sheltered homeless individuals and families in Quincy region in emergency shelters and transitional housing.

Given the desire to build on aspects of the system that are already working well, the Quincy Regional Committee determined that ***multiple but , limited points of entry, a more centralized implementation model,*** (a more centralized implementation model with limited points of entry) would be the most appropriate model in Quincy/Adams County. A team of trained Assessment Specialists would be responsible for:

- Providing diversion assistance, if possible and as appropriate based on the household's needs and circumstances
- Administering the assessment to determine the type of intervention needed to resolve the household's homelessness
- Determining an interim housing placement (as appropriate and available);
- Ensuring a specific staff person is assigned to each household and a warm handoff occurs

- Developing capacity to ensure all clients are assessed in an agreed time period (within 72 hours)

The Salvation Army and Madonna House will be the providers providing the trained Assessment Specialist. The trained Assessment Specialist will use the VI-SPDAT and full SPDAT as explained in the next section (Procedures).

Domestic Violence piece of this is currently being investigated on how to properly conduct per VAWA/VOCA guidelines.

C. Jacksonville Regional Implementation

The Jacksonville area is starting to gather provider information. The 2015 Housing Inventory Chart shows Jacksonville/Morgan County has 4 providers that provide emergency and transitional housing. Quincy is the first region in the CoC to implement the coordinated assessment process. The lessons learned thru the Quincy implementation will enable Jacksonville to have a smoother implementation. Jacksonville providers are part of the Coordinated Assessment Workgroup, see Appendix B.

D. Macomb Regional Implementation

The Macomb area is starting to gather provider information. The 2015 Housing Inventory Chart shows Macomb/McDonough County has 2 providers that provide emergency and transitional housing. Quincy is the first region in the CoC to implement the coordinated assessment process. The lessons learned thru the Quincy implementation will enable Macomb to have a smoother implementation. A Macomb provider is part of the Coordinated Assessment Workgroup, see Appendix B.

IV. Procedures

A. Accessing Emergency Shelter and Services

Quincy Region

Primary access points for people in crisis include the Salvation Army and Madonna House. Individuals and families may call or walk-in to these physical locations. The locations are open seven days a week, 24-hours a day, 365 days a year. Individuals and families are referred by a broad network of sources including word of mouth, Quincy Police Department community policing liaisons, clergy, and other social services providers.

Within 72 hours, individuals and families residing in shelter will be given the full SPDAT. If an individual or family is unsheltered, they will be given a VI-SPDAT, if they qualify for PSH or RRH they will be given a full SPDAT within 15 days**.**

Jacksonville Region

Information to come.

Macomb Region

Information to come.

B. Determining Eligibility for Homeless Services (Emergency Response Screening)

The purpose of this step is to ensure that people are not admitted to the shelters if they have resources that can keep them housed elsewhere; in their own home, with family, with friends, in a hotel, etc. This helps reserve scarce shelter resources for those most in need. "Diversion" is a term used for the assistance provided to individuals and families standing at the front door of the system seeking shelter/housing. The tools are very similar to those used in prevention and rapid re-housing programs, including assistance with arrears, short-term rental assistance, landlord mediation, connection to mainstream benefits and services, etc. The tools and resources required for diversion are similar in nature to those used in prevention and rapid re-housing programs, including (but not limited to):

- Negotiation and/or mediation with landlords, family members, etc. to preserve or save a housing situation
- Financial assistance for rental or utility arrears, short-term rental assistance, etc.
- Exploration of support networks to consider family members, friends, churches, or other options that may provide an alternative to entering shelter including negotiation with other housing providers, such as PHA, who may consider extended house guests as a lease violation, placing host families at risk
- Crisis counseling and referral to mainstream service providers to assist with issues related to domestic violence, health, employment, etc.

The key difference between diversion, prevention, and rapid re-housing relates not as much to the type of assistance provided, but rather when that assistance is provided. Whereas prevention assistance is provided while an individual or family is still housed, and rapid re-housing is provided to households that have lost their housing and entered the homeless services system, diversion is a term used for the assistance provided to those standing at the front door of the system seeking shelter/housing.

Participating providers will administer the Emergency Response Screening (Appendix C).

C. Housing Barriers Assessment & Prioritization Screening (VI-SPDAT and Full SPDAT)

The Housing Barriers Assessment (VI-SPDAT and full SPDAT) will be administered by a trained Assessment Specialist. To households who are shelter guests or living in places not meant for human habitation.[2] This is a secondary process that follows the initial pre-screening (Emergency Response Screening). It is intended to assess housing barriers and to connect people to the resources needed to regain housing stability. The assessment is generally completed within 72 hours of acceptance into emergency shelter/ housing.

The VI-SPDAT has a built-in scoring mechanism that will prioritize households for access to different housing interventions. This will serve as a jumping-off point for a discussion between the assessment staff member and the consumer about what referral should be made. The framework identifies three permanent housing interventions, and is based on the principle of providing the least intervention necessary to promote housing stability for the client or client family. This strategy, sometimes referred to as "right-sizing" assistance or "just enough" assistance, is important because WCICCC has more demand for housing assistance than available resources. Simply put, the homeless services system is not resourced to provide permanent subsidies to every household in the system, and providing more assistance than a household truly needs to resolve the housing crisis means others in the system do not get assisted at all. As such, the assessment screening aims to identify which permanent housing intervention best meets each client's need.

If the VI-SPDAT indicates medium or high level intervention is needed, then a full SPDAT will be used to prioritize housing referrals for rapid rehousing and PSH. It will be used on persons within two-weeks of entering shelter and who have been determined to have multiple barriers to housing stability. Below is a description of the different intervention levels:

- ***Lowest intervention: Minimal Housing Assistance***
  This intervention is considered to be a very light touch. The individuals assigned to this pathway are those that could not be diverted but are likely to resolve their homelessness on their own or with very minimal assistance. The Coordinated Assessment Workgroup envisions that an individual case manager may not be need, though the Assessment Specialist may provide referrals to mainstream service providers, and access to group case management or informational workshops may be provided (e.g., budgeting/ financial literacy, tenant rights and responsibilities). In addition, one-time financial assistance (e.g., assistance with arrears, security deposit and move-in assistance) may be needed.

[2] Quincy region this will be done by the Assessment Specialist. Domestic violence providers will administer the screening tools to their clients. Assessment Specialist will enter the data into the HMIS. Domestic violence providers are prohibited from entering the data into the HMIS.

- ***Medium intervention: Rapid Re-Housing (RRH)***
  The next level of intervention is short- (up to 3 months) to medium-term (4 to 24 months) assistance[3]. While financial assistance (e.g., arrears, security deposits, rental assistance, and utility assistance) is part of this support, case management and supportive services are equally important. The assistance is not one-size-fits-all, but rather titrated based on each client's unique needs and circumstances.

- ***Medium intervention: Transitional Housing (TH)***
  Another medium intervention is transitional housing. Transitional housing programs provide temporary residence up to 24 months for people experiencing homelessness. Housing is combined with wrap-around services to assist the individual with developing stability in their lives.

  WCICCC has two types of transitional housing available in the area; transitional shelters and scattered site transitional housing. Transitional shelters are programs that operate in buildings or converted homes and assign a room to an individual or family to use while in their program receiving services. Scattered site transitional housing uses existing rental units in their area for housing for clients. The availability of each type of transitional housing varies by region.

- ***Highest intervention: Transitional Housing (TH)***
  In the Macomb region, permanent supportive housing is not available. Therefore, scattered site transitional housing would be the highest intervention available to individuals and families wanting to locate in Macomb. This is a temporary residence; clients can stay up to 24 months.

- ***Highest intervention: Permanent Supportive Housing***
  The most intensive (and most expensive) intervention is permanent supportive housing (PSH). PSH should be reserved for those individuals and families who are unable to remain stably housed "but for" a permanent subsidy and ongoing supportive services.

Relevant data points (at minimum the HUD UDEs) will be entered into HMIS.

D. Housing Referrals

When PSH or RRH beds become available, these housing providers will call a meeting about the vacancies. Eligible individuals or families will be identified using the Housing Barriers Assessment and Prioritization Screening (VI-SPDAT and full SPDAT) described above. A list of eligible individuals/families will be pulled from the HMIS database. Since Domestic Violence providers cannot enter their assessments into the HMIS, they will bring a listing of eligible individuals or families to the meeting. The housing provider will contact referred households to update their information and verify that they are still eligible for and want the openings.

[3] HUD's *Rapid Re-Housing ESG vs. CoC*, available: https://www.hudexchange.info/resources/documents/Rapid_Re-Housing_ESG_vs_CoC.pdf, Page 6, created: March 12, 2013.

If a household does not qualify or is declined for another reason, the housing provider will work through the referrals in priority order until one household qualifies and is accepted. For each unqualified/ineligible household, the provider must supply a detailed description to the referring entity of why the household was not accepted. If there are repeated problems with ineligible referrals, providers should provide updated information to the Regional Committee.

For the safety of domestic violence survivors, providers should NOT list domestic violence in their database as the reason for declining a referral when a household qualifies for domestic violence services but the receiving provider is not equipped to handle such cases.

Completed referrals must then be acknowledged (accepted, declined by provider, declined by client, pending, or unable to reach client) by the housing provider as quickly as possible.

Once a household is determined eligible, the receiving provider should call or e-mail the shelter or outreach staff that made the referral in order to complete the application process. The receiving provider should tell the referring staff whether the client accepted or declined the housing option.

Housing providers must regularly update and circulate all program eligibility guidelines and program contact information to maximize the accuracy and eligibility of referrals.

E. Completing the Housing Intake Process

The housing intake process will be handled by PSH or RRH program staff after a referral is sent by emergency shelter or transitional housing staff to the program contact. Completion of this process is required for admission to PSH or RRH. The intake process will incorporate all information gathered from the individual or family during previous assessments in order to reduce duplication and re-interviewing.

F. Documentation

Shelter or outreach staff will collect documentation of homelessness and transmit it to the receiving housing provider at the time of referral. This documentation should be faxed or mailed, not emailed due to confidentiality concerns. In most programs homeless certifications are good for 90 days, except when the household is entering housing funded through the HUD CoC-funded program. Certifications of homeless status must be provided in writing. HUD requires that clients entering CoC-funded program must be in shelter the night before entry into the PSH. If a household has been on the placement roster for more than 90 days and an opening becomes available in appropriate housing; housing providers will call the referring staff to confirm homeless status and obtain a new written verification. The following are acceptable forms of homeless verification:

1. Documentation of chronic homeless (including bed nights and clinical diagnosis)
2. For literally homeless households(at least one of the following is needed):

- Written observation by an outreach worker or other professional
- Written referral by another housing or services provider (such as a shelter)
- A three-day sheriff's notice (writ of restitution) as part of a legal eviction process
- Certification by the individual or head of household seeking assistance stating that (s)he was living on the streets or in shelter, preferably accompanied by a third party verification.

3. For households staying with family or friends, a dated letter from the homeowner or leaseholder that the household in question must leave within 72 hours and certification by the individual or head of household seeking assistance stating that (s)he will become homeless within 72 hours. [4]
4. For individuals exiting an institution, one of the forms of evidence above and:[5]
    - Discharge paperwork or written/oral referral,
    - Written record of intake worker's due diligence to obtain above evidence and certification by individual that they exited institution.
5. Income:[6]
    - Shelter or outreach staff will verify income eligibility and collect current income documentation at the time of assessment.
    - All income documentation will be passed onto the provider accepting the household at the time of referral.

G. Guidelines for Unfilled Openings in HUD CoC-funded Housing

Whether vacancies are expected or not, every effort should be made to fill available units as quickly as possible using the Housing Barrier Assessment, referral, intake, and placement steps stated above.

H. Data Collection

Data will be collected on everyone that is assessed through the coordinated assessment process. This section, in addition to instructions embedded within the assessment screening, will detail when and how data about consumers going through coordinated assessment will be collected.

Once a client has completed the Emergency Response Screening and is deemed eligible to be assessed, the trained Assessment Specialist will show the consumer the data confidentiality form. They will go over it with them and explain what data will be requested, how it will be shared, who it will be shared with, and what the consumer's rights are regarding the use of their data. The Assessment Specialist will be responsible for ensuring consumers understand their rights as far as release of information and data confidentiality. If they sign the form, the Assessment Specialist will begin the assessment process. If the assessment is not directly

[4] Not acceptable documentation for HUD CoC-funded PSH.
[5] Not acceptable documentation for HUD CoC-funded PSH.
[6] No income guidelines for HUD CoC-funded PSH; normally a disabling condition makes it difficult for them to manage their finances and these individuals are prone to being taken advantage of by other.

entered into the HMIS, assessments should be completed on paper initially with relevant data entered into the data fields in ServicePoint within 24 hours of completing the assessment.

Some consumers should never be entered into ServicePoint HMIS. These include:

- Consumers who want domestic violence-specific services should never have information entered into the ServicePoint HMIS. The assessment should be done on a paper form and passed off to the appropriate provider. If they are being served by a domestic violence provider, that agency may enter their information into a HMIS-comparable database.
- Consumers who do not sign a data confidentiality form should have their data entered into HMIS as an anonymous client (Appendix D).

Once the assessment process has been completed, the Assessment Specialist will share the consumer's record in ServicePoint (or the paper form) with the program they are being referred to. This way the program will have the consumer's information and can ensure they do not ask the same questions again, potentially re-traumatizing the consumer.

Relevant data points, at minimum the Universal Data Elements (UDEs), will be entered into HMIS.

V. Evaluation

A. Evaluation Method

The coordinated assessment process will be evaluated on a regular basis to ensure that it is operating at maximum efficiency. Evaluation will be carried out primarily through the Coordinated Assessment Workgroup and the Support Entity. Evaluation mechanisms will include the following:

- A review of metrics from the coordinated assessment process. The data to be reviewed, and the thresholds that should be met, will be developed based on the document in Appendix E.
- A consumer satisfaction survey with people experiencing homelessness who have been through the coordinated assessment process (Appendix F).
- A report issued to the community every six months on coordinated assessment and homelessness assistance system outcomes. This report will include trends from the quarterly analysis of coordinated assessment data, as well as the total number of assessments and referrals made, successes to be shared, and a note from the Coordinated Assessment Workgroup Chair on the process's progress. Major findings from this report should be presented at the CoC meeting the month it is released by a

member of the Coordinated Assessment Workgroup and West Central Illinois Homeless Assistance Council.

Appendix A: HUD Definitions of Homelessness

Category 1 Literally Homeless	Individuals who lack a fixed, regular, and adequate night time residence, meaning: • Have a primary residence that is a public or private place not meant for human habitation; • Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); **or** • Is exiting an institution where (s)he has resided for 90 days or less **and** who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution
Category 2 Imminent Risk of Homelessness	An individual or family who will imminently lose their primary nighttime residence, provided that: • Residence will be lost within 14 days of the date of application for homeless assistance; • No subsequent residence has been identified; **and** • The unaccompanied youth or young adult lacks the resources or support networks needed to obtain other permanent housing
Category 3 Unac-companied Youth Under Age 25	Unaccompanied youth under age 25, or families with children and youth, who do not otherwise qualify as homeless under these definitions: • Defined as homeless under Runaway and Homeless Youth Act, Head Start Act, Violence against Women Act, Public Health Service Act, Food and Nutrition Act of 2008, Child Nutrition Act of 1966, or McKinney-Vento Homeless Assistance Act; • Have not had a lease, ownership interest, or occupancy agreement in permanent housing in the 60 days preceding application for assistance; • Have experienced persistent instability as measured by two move or more in 60 during in the preceding 60 days; **and** • Can be expected to continue such status for an extended period of time due to
Category 4 Fleeing/ Attempting to Flee DV	Any individual or family who: • Is fleeing, or is attempting to flee, domestic violence;; **and** • Has no other residence; **and** • Lacks the resources or support networks to obtain other permanent housing

Appendix B: Coordinated Assessment Workgroup & Plans

Name	Organization	Region
Mary Muehlenfeld	YWCA of Quincy	Quincy
Myndi Boyd	YWCA of Quincy	Quincy
Cynthia Grawe	Madonna House	Quincy
Megan Duesterhaus	QUANADA	Quincy
Jennifer Vancil	QUANADA	Quincy
Heidi Welty	Salvation Army of Quincy	Quincy
Emily Beaver	Salvation Army of Quincy	Quincy
Dona Leanard	Crisis Center Foundation	Jacksonville
Tammi Lonergan	MCS Community Services	Jacksonville
Suzan Nash	Western Illinois Regional Council	Macomb
Lori Sutton	Illinois Institute for Rural Affairs, Western Illinois University	Support Entity
Amanda Davis	Illinois Institute for Rural Affairs, Western Illinois University	Support Entity

- **Emily Beaver.** Emily is HMIS and Assessment Coordinator for the Salvation Army in Quincy, IL. She enters all the data entry from Family Services and the Emergency Shelter. Along with being the lead of the Coordinated Assessment in the Salvation Army, she also assists with doing assessments for the shelter clients and doing case management with them. When needed, Emily Family Services side as a case manager. Emily serves on the Unmet Needs Committee at United Way, too.
- **Myndi Boyd.** Myndi is also a member of the CoC's Governing Board. Myndi is employed at the YWCA of Quincy as a Case Manager Assistant. She has many roles at the YWCA including outreach coordination with our homeless population; serving on the Unmet Needs Committee at United Way, entering all data for YWCA homeless programs in the HMIS and assisting program participants with life skills. Myndi is a formerly homeless person and has firsthand experience as a program participant in the YWCA Supportive Housing Program.
- **Megan Duesterhaus.** Megan is the Executive Director of Quanada. She holds a Doctorate of Philosophy in Sociology from the University of Central Florida and is an Illinois Certified Domestic Violence Professional. She has been with Quanada for five years. Quanada serves victims of domestic and sexual violence in the Illinois counties of Adams, Brown, Schuyler, Pike, and Hancock and is the first pet-friendly domestic violence shelter in the state. Quanada's domestic violence shelter currently receives ESG funds.
- **Cindy Grawe.** Cindy is the Prevention Director for Madonna House in Quincy. She has had many roles at Madonna House over the last 8 years. Prior to becoming the Prevention Director, Cindy was the Shelter Director for the past 7 years. As the Prevention Director, Cindy provides outreach coordination with our homeless population; enters HMIS data for Madonna House, and is serving on the Unmet Needs Committee at United Way, All Our Kids of Adams County, and Health Delegation of Adams County United Way.
- **Dona Leanard.** Dona chaired the group and is also on the West Central Illinois Homeless Assistance Council, which is the CoC's Governing Board. Dona is the Executive Director at the Crisis Center Foundation in Jacksonville. Crisis Center works with victims of domestic violence, a population susceptible to homelessness. Her agency is an ESG recipient and she has been an active participant in the Continuum of Care for years. Dona represents an appointed-advisory seat representing ESG programs for our Governing Board.
- **Tammi Lonergan.** Tammi is the Housing Coordinator for MCS Community Services in Jacksonville. Our agency is a Community Action Agency (CAA) that serves Morgan, Cass, and Scott counties. MCS administer the Dept. Commerce & Economic Opportunities – Community Services Block Grant (CSBG); Dept. of Human Services – Homeless Prevention Grant and Emergency Transitional Housing Grant; Dept. of Health & Human Services – Low Income Home Energy Assistance Program (LIHEAP) and Illinois Home Weatherization Program (IHWAP); and HUD – Emergency Solutions Grant and Permanent Supportive Housing Grants. Tammi has been with the agency for 18 years, 12 of those years involved with the Continuum of Care. She is the administrator, case manager, and data entry person for the CSBG, DHS, and HUD grants within the agency.
- **Mary Muehlenfeld.** Mary co-chair for the Coordinated Assessment Committee. Mary serves as the Collaborative Applicant for the CoC. Collaborative Applicant are responsible for making sure that the CoC is in compliance with the HEARTH Act and is responsible for registering the CoC for funding opportunities and for submitting the CoC grant applications annually. Collaborative Applicant is also the fiscal agent for the CoC's HUD planning grants and the HMIS grant funds from HUD. Mary is the Executive Director of the YWCA of Quincy. The YWCA of Quincy receives

HUD CoC funding for Permanent Supportive Housing in the Quincy area and they are looking at expanding to the Macomb area.

- **Suzan Nash.** Suzan is the Executive Director of the Western Illinois Regional Council and Community Action Agency (WIRC-CAA) in Macomb. The WIRC-CAA serves four counties and provides a variety of services to the income eligible including food, clothing, and housing for the homeless. Additionally, the agency provides services to victim of domestic and sexual violence. Suzan and her agency have been actively involved in the Continuum of Care since its initial organization and WIRC-CAA currently receives funding from DHS to provide emergency transitional and homeless prevention services to eligible individuals and families.
- **Jennifer Vancil.** Jennifer is the Program Director for Quanada. She has been in this position for a year. She is also on the program council for Illinois Coalition against Domestic Violence and on the Justice and Accountability subcommittee. She has worked in several different positions at Quanada. She served as their Legal Advocate for over a year and then switched roles and became their Adult Counselor.
- **Heidi Welty.** Heidi is the Regional Social Services Director for The Salvation Army in Hannibal Missouri and Quincy Illinois. She is the Director for both Family Service centers in Hannibal and Quincy as well as the 14 bed emergency shelter. Heidi has been employed with The Salvation Army for nine years. Heidi graduated from Western Illinois University with a Master in Science degree from the Counseling Education department. The emergency shelter program currently receives ESG funds.
- **Amanda Davis and Lori Sutton.** Amanda and Lori serve as the Council's Support Entities. They work for Illinois Institute for Rural Affairs (IIRA) at Western Illinois University in Macomb. IIRA provides data analysis and technical assistance to grant recipients in our CoC; oversees the administration of the HMIS utilized by homeless service providers in our CoC; coordinates the Point-In-Time Count for our CoC; train users on the HMIS; and in the future will train users on using the Coordinated Assessment prioritization screening tool (VI-SPDAT and full SPDAT).

Quincy Regional Plan

Macomb Regional Plan

Jacksonville Regional Plan

WCICCC Regional Committee Plan

Date: November 6, 2015

Regional Committees within the WCICCC will design coordinated assessment plans using this form.

Regional Committee	Quincy Regional Committee
Counties Served:	Adams County
Regional Lead Agency I:	Salvation Army
Regional Lead Agency II:	Madonna House

ACCESS TO SYSTEM

Regional Committees within the WCICCC will use one of two approved coordinated assessment models. Please indicate your Regional Committee model below (choose one):

☒ **Designated agency(s)** administer both emergency response screening and VI-SPDAT assessment tool and make program referrals for the system

☐ **All agencies** will uniformly administer both emergency response screening and VI-SPDAT assessment tool and make program referrals

List of agencies administering emergency response screening:

Madonna House
Salvation Army

Agencies acting as coordinated assessment sites within Regional Committee:

Agency	Administering the Emergency Response Screening	VI-SPDAT for families, individuals or both	Number of staff for coordinated assessment	Time/week for staff to do coordinated assessment	Schedule of staff available for coordinated assessment (example: Mon-Fri, 8 am – 5pm)
Madonna House	☒Yes ☐No	☐Families only ☐ Individuals only ☒Both ☐Neither	3	24/7 Monday-Sunday	24/7 Monday-Sunday
Salvation Army	☒Yes ☐No	☐Families only ☐ Individuals only ☒Both ☐Neither	4	24/7 Monday-Sunday	24/7 Monday-Sunday
	☐Yes ☐No	☐Families only ☐ Individuals only ☐Both ☐Neither			
	☐Yes ☐No	☐Families only ☐ Individuals only ☐Both ☐Neither			
	☐Yes ☐No	☐Families only ☐ Individuals only ☐Both ☐Neither			
	☐Yes ☐No	☐Families only ☐ Individuals only ☐Both ☐Neither			
	☐Yes ☐No	☐Families only ☐ Individuals only ☐Both ☐Neither			

How will individuals access homeless programs in your community? (Should correspond to diagram for individual access in Appendix C)

Given the desire to build on aspects of the system that are already working well, the Quincy Regional Committee determined that multiple but limited points of entry, with a centralized implementation model would be the most appropriate model in Quincy/Adams County. A team of trained Assessment Specialists would be responsible for:

- Providing diversion assistance, if possible and appropriate based on the household's needs and circumstances;
- Administering the assessment to determine the type of intervention needed to resolve the household's homelessness;
- Determining an interim housing placement (as appropriate and available);
- Ensuring a specific staff person is assigned to each household and a warm handoff occurs; and
- Developing capacity to ensure all clients are assessed in an agreed time period (within 72 hours).

The Salvation Army and Madonna House will be the sites providing the trained Assessment Specialist. The trained Assessment Specialist will use the VI-SPDAT and full SPDAT as explained in the next section (Procedures).

The plan for domestic violence victims is currently being investigated on how to properly conduct per VAWA/VOCA guidelines.

How will families access homeless programs in your community? (Should correspond to diagram for family access in Appendix C)

According to the 2015 Housing Inventory Count performed in January, there were 19 providers that sheltered homeless individuals and families in the Quincy region in emergency shelters and transitional housing.

Are people required to travel to different locations to access programs and services in your community?

☒ Yes ☐ No

If yes, what happens if a household is unable to access transportation?

Salvation Army and Madonna House are the centralized locations for the completion of the Housing Barriers Assessment and Prioritization Screening (VI-SPDAT and SPDAT). This screening will not require transportation. The Salvation Army and Madonna House will conduct assessments at the location of homeless individuals. However; transportation may be required to assess households in the safe environment of the assessment sites. Quincy has a public transit system and can be used to assist individuals and families to get to needed agencies if travel is required.

How is coordinated assessment advertised in your community? (check all that apply)

☒ All agencies aware ☒ Posters ☒ Billboards ☒ Media stories ☒ Flyers

☐ Stickers ☒ Community Forum ☐ Other (Please describe:_____)

How does your community connect coordinated assessment to existing systems? Please describe what is available locally and how the systems overlap and interact.

Prevention services:

There is a solid network of agencies who participate in the Regional Committee that have built strong relationships to assist each other in serving individuals and families to prevent homelessness. The coordinated assessment will naturally begin with the known agencies to the community that give crisis assistance. The Quincy Regional Committee uses Service Point HMIS database to track movement and services; as well as other providers in the area.

Veterans Affairs:

Communication about the coordinated assessment and the process for referral will be provided to Veterans Affairs providing crisis assistance for those homeless or at risk for homelessness. Updates will be provided through provider forums and collaborative meetings. A representative from Veteran Affairs is part of the continuum and invited to conference calls.

Faith-based poverty programs:

Communication about the coordinated assessment and the process for referral will be provided to faith-based organizations providing crisis assistance for those homeless or at risk for homelessness through the local ministerial alliance and the Unmet Needs Comittee.

Mental health services:

Communication about the coordinated assessment and the process for referral will be provided to behavioral health organizations providing crisis assistance for those homeless or at risk for homelessness. Updates will be provided through provider forums and collaborative meetings.

Legal/judicial system, including law enforcement and prisons:

Law enforcement, prisons, and judicial systems will be made aware of entry points for the coordinated assessment.

Communication about the coordinated assessment and the process for referral will be provided to Department of Human Services providing crisis assistance for those homeless or at risk for homelessness. Updates will be provided through provider forums and collaborative meetings.

REFERRALS

Please describe how the referral process will work in your community. If clients need to transfer agencies in the referral process, please describe how this will be done.

When PSH or RRH beds become available, these housing providers will call a meeting about the vacancies. Eligible individuals or families will be identified using the Housing Barriers Assessment and Prioritization Screening (VISPDAT and SPDAT). The housing provider will contact referred households to update their information and verify that they are still eligible for and want the openings.

If a household does not qualify or is declined for another reason, the housing provider will work through the referrals in priority order until one household qualifies and is accepted. For each unqualified/ineligible household, the provider must supply a detailed description to the referring entity of why the household was not accepted. If there are repeated problems with ineligible referrals, providers should provide updated information to the Regional Committee.

For the safety of domestic violence survivors, providers should NOT list domestic violence in their database as the reason for declining a referral when a household qualifies for domestic violence services but the receiving provider is not equipped to handle such cases.

Completed referrals must then be acknowledged (accepted, declined by provider, declined by client, pending, or unable to reach client) by the housing provider as quickly as possible.

Once a household is determined eligible, the receiving provider should call the shelter or outreach staff that made the referral in order to complete the application process. Documentation pertaining to the client should be faxed or mailed, not emailed due to confidentiality concerns. The receiving provider should tell the referring staff whether the client accepted or declined the housing option.

Housing providers must regularly update and circulate all program eligibility guidelines and program contact information to maximize the accuracy and eligibility of referrals.

Are transportation funds/resources provided? ☒ Yes ☐ No

If yes, please describe resources, to whom they are available, and how and when they are accessed.

The YWCA of Quincy has funding available to assist female victims of domestic violence

and their children with the costs of transportation to flee a domestic violence situation. Funding is limited to $50 per victim and the referral must be made by a DV service provider on their behalf.

The YWCA of Quincy has funding available to assist homeless families with transportation costs to Quincy to reside in the YWCA Permanent Supportive Housing Program. The family must have completed the application process for the PSH program, have met the eligibility criteria and accepted the terms and conditions of the PSH program in order to receive assistance.

Are forms sent with clients and/or included in HMIS? ☒ Yes ☐ No

If yes, please describe:

Copies of the Housing Barriers Assessment and Prioritization Screening (VISPDAT and SPDAT) and referrals will be presented to individuals upon completion. A universal referral form will also be developed and given to the client.

Does your Regional Committee use real-time bed availability? ☐ Yes ☒ No

If yes, please describe:

Due to the lack of all providers being on HMIS, ability to show real-time bed availability is difficult.

What is the process for agencies that do not want to accept referrals coming from coordinated assessment?

For each unqualified/ineligible household, the provider must supply a detailed description to the referring entity of why the household was not accepted. If there are repeated problems with ineligible referrals, providers should provide updated information to the Regional Committee.

There may be rare instances where programs decide not to accept a referral from the coordinated assessment process. Refusals are acceptable only in certain situations, including:

- No vacancy exists in program;
- The person does not meet the program's eligibility criteria;
- The person would be a danger to others or themselves if allowed to stay at this particular program; and
- The person has previously caused serious conflicts within the program (e.g. was violent with another consumer or program staff).

If the program determines a consumer is not eligible for their program, the consumer should be sent back to their initial assessment point for staff to determine a place for them to sleep that night (if they do not already have one). If assessment hours are done

for the day, they should be referred to population-appropriate emergency shelter. Within 48 hours of their re-entry into shelter, a representative from the program that refused them, the assessment staff member, and the consumer experiencing homelessness must meet to determine the best next step for the consumer. Any cases that are unable to be resolved to the consumer's satisfaction will be referred to the Regional Committee to be handled by the grievance procedure process. If a program is consistently refusing referrals (more than 1 out of every 4) they will need to meet with the Coordinated Assessment Committee to discuss the issue that is causing the refusals.

What is the grievance process for individuals who do not agree with their referral?

The assessment staff member or the assessment staff supervisor should address any grievances by consumers as best as they can in the moment. Grievances that should be addressed directly by the assessment staff member or assessment staff supervisor include grievances about how they were treated by assessment staff, assessment center conditions, or violation of confidentiality agreements. Any other grievances should be referred to the chair of the Regional Coordinated Assessment Committee to be dealt with in a similar process to the one described above for providers. Any grievances filed by a consumer should note their name and contact information so the chair can contact them. The grievance needs to be filed within 24 business hours. The Regional Coordinated Assessment Committee will consist of peer agencies in the community that will listen to the grievance. A decision regarding the grievance will be finalized within 72 business hours of grievance and the consumer will be notified immediately. The program decision stands for the duration of the grievance process. Grievances that reach the Regional Coordinated Assessment Committee will be filed with the Support Entity for record retention.

How does your Regional Committee handle waitlists for programs? Please include information for how this waitlist is created, stored, and updated and the agency/person responsible.

Each agency will coordinate their own wait lists for program services. Wait lists consist of those who meet program requirements. Referrals for services are made to those who present for shelter.

When PSH or RRH beds become available, these housing providers will call a meeting about the vacancies. Eligible individuals or families will be identified using the Housing Barriers Assessment and Prioritization Screening described above. The housing provider will contact referred households to update their information and verify that they are still eligible for and want the openings. Individuals that are still eligible will be be prioritized based on their SPDAT score for the order of the waiting list. These scores will be kept in ServicePoint.

Coordinated assessment will help communities to identify gaps in services. How will your community address these gaps as they become apparent?

Once the system is in place and operating we will be able to recognize obstacles and deficiencies and address these in regional and agency meetings to come up with solutions. Brainstorming and identifying programs and agencies already in place that

addresses these gaps will assist in rectifying problems. Data collection will also be utilized to address gaps and needs.

OVERSIGHT

The Coordinated Assessment Lead will be tasked with reporting about coordinated assessment on measures set by the Coordinated Assessment Council. Will your Regional Committee engage in further measures (e.g. including weekly case management meeting to case conference, monthly provider meeting to assess system flow, elected group to monitor local grievances)? Please describe below.

Quincy Regional Committee will meet monthly to discuss issues of monitoring and flow. Case conferencing and grievance matters will also be discussed as they are determined.

Regional Committee: Quincy Region

Please list all programs within your Regional Committee that serve people who are homeless. If an agency operates more than one program, please list each program separately. Regional Committees are responsible for extending information and invitations to participate in coordinated assessment.

Organization Name	Project Name / Service	Contact Phone	Address	Website	Population Served:			
					Men	Women	Families	Youth
Adams County Health Department		217-222-8440	330 Vermont St. Quincy, IL 62301	http://www.co.adams.il.us/Health/index.htm	X	X	X	
American Red Cross	Disaster Relief	217-222-2477	3000 N. 23rd. St. Quincy, IL 62305	www.redcross.org/il/quincy	X	X	X	
Avenues	Deomestic & Sexual violence Advocacy Services	573-406-1400 or 800-678-7713	PO Box 284 Hannibal, MO 63401	www.avenueshelp.org	X	X	X	
Birthright of Quincy	Crisis Pregnancy Center	217-224-1277	1200 Broadway St. #A, Quincy,l IL 62301	http://www.birthrightquincyil.org/	X	X	X	
Blessing Hospital	Healthcare	217-223-1200	1005 Broadway St. Quincy, IL 62301	https://www.blessinghospital.org/	X	X	X	
CareNet	Crisis Pregnancy Center	217-223-8200	436 S. 6th St. Quincy, IL 62301	http://carenetquincy.com/	X	X	X	
Catholic Charities		217-523-9201	620 Maine St. Quincy, IL 62301	http://cc.dio.org/	X	X	X	
Child and Family Connections (Regional Office of Education)	Birth to 3 early intervention services	217-222-9592 or toll free 1-888-222-9592	510 Maine Street, Quincy, IL 62301	http://www.wc4.org/page.php?id=19	X	X	X	
Community of Christ		217-228-1841	3524 S. 36th St. Quincy, IL 62305	https://www.facebook.com/pages/Community-of-Christ/139111652803399	X	X	X	
Community Outreach Clinic	Non-emergency primary care for adults	217-223-8400	PO Box 7005 Quincy, IL 62305	http://www.blessinghealthsystem.org/?id=861&sid=1	X	X	X	
Cornerstone Foundation for Families	Counseling services	217-222-8254	915 Vermont St. Quincy, IL 62301	http://www.cornerstone-quincy.org/				
Department of Children and Family Services	Child welfare agency	217-524-2029	406 E. Monroe St. Quincy, IL 62305	http://www.illinois.gov/dcfs/Pages/default.aspx	X	X	X	
DHS (Public Aid)		217-223-0550	300 Main St. 2nd floor Quincy, IL 62301	www.dhs.state.il.us/page.aspx?module=12&officetype=&county=Adams	X	X	X	

Organization Name	Project Name / Service	Contact Phone	Address	Website	Men	Women	Families	Youth
Early Childhood and Family Center		217-223-8700	401 S. 8th St. Quincy, IL 62301	https://www.qps.org/ecfc/	X	X	X	
Family Planning	Educates patients about taking responsibility for reproductive heath and provdies health care regardless of income, race, age,	217-224-6877	636 Hampshire St. #201 Quincy, IL 62301	http://www.familyplanningquincy.org/	X	X	X	
Fishers of Men		217-617-7000	609 N. 6th St. Quincy, IL 62301	fomquincy.com/index.html	X			
General Assistance	Financial assistance and resources for paying rent, utility bills, food, medications, and household items.	217-223-4970	706 Main St. Quincy, IL 62301	no website	X	X	X	
Hope House	Transitional Housing	573-221-2261	1611 Hodiamont Ave. St. Louis, MO 63401	No website	X	X	X	
Horizons Social Services	Soup kitchen	217-224-5530	701 Hampshire St. Quincy, IL 62301	http://horizonssocialservices.com/	X	X	X	
Housing Authority	Affordable housing	217-222-0720	540 Harrison St. Quincy, IL 62301	http://affordablehousingonline.com/housing-authority/Illinois/Quincy-Housing-Authority/IL016/	X	X	X	
Illinois Dept of Employment Services		800-244-5631	107 N. 3rd St. Quincy, IL 62301	http://www.ides.illinois.gov/Pages/default.aspx	X	X	X	
John Wood Community College	Adult Education	217-224-6500	1301 S. 48th St. Quincy, IL 62305	https://www.jwcc.edu/	X	X	X	
Ladies of Charity		217-222-3541	934 N. 12th St. Quincy, IL 62301	https://www.facebook.com/pages/Ladies-of-Charity/154950014543708	X	X	X	
Madonna House	Transitional housing and emergency shelter	217-224-7771	405 S. 12th St. Quincy, IL 62301	www.madonnahouse.net		X	X	
Madonna House	Food Pantry and Prevention	217-224-7772	405 S. 12th St. Quincy, IL 62301	www.madonnahouse.net	X	X	X	
Madonna House	Everyday Life Skills-Adult	217-224-7774	405 S. 12th St. Quincy, IL 62301	www.madonnahouse.net	X	X		
Madonna House	Everyday Life Skills- After School and Teen	217-224-7775	405 S. 12th St. Quincy, IL 62301	www.madonnahouse.net				X

Organization Name	Project Name / Service	Contact Phone	Address	Website	Men	Women	Families	Youth
New Start Rescue Mission	Emergency shelter	217-223-2100	936 N. 6th St. Quincy, IL 62301	http://www.faithpresquincy.org/content.cfm?id=355	X			
Quanada	Transitional housing and emergency shelter (Adams, Brown, Hancock, Schuyler and Pike)	212-222-0069 or 800-369-2287	2707 Main St. Quincy IL, 62301	www.quanada.org	X	X	X	
Recovery Resources and Family Center	Adult residential, IOP/OP Substance	217-224-6300	428 S. 36th St. Quincy, IL 62301	https://www.pfh.org/locations/	X	X	X	
Salem Church		217-222-0601	435 S. 9th St. Quincy, IL 62301	http://www.salemquincy.org/	X	X	X	
Salvation Army Emergency Shelter	Emergency shelter	217-222-8655	323 N. 5th St. Quincy, IL 62301	www.salvationarmyquincy.org/emergency-shelter/	X	X	X	
Salvation Army Family Services		217-222-5762	501 Broadway St. Quincy, IL 62301	www.salvationarmyquincy.org/family-services/	X	X	X	
Sexual Assult Prevention and Intervention Serivces (Quanada)	Supportive services to victims of sexual assault	217-223-2030 or 800-369-2287 Home	1900 Harrison, Quincy, IL 62301	www.quanada.org	X	X	X	
Social Security Administration	Social Security information	888-279-5999	2401 Lind St. Quincy, IL 62301	www.ssa.gov	X	X	X	
The Crossing Church		217-224-6374	150 S. 48th St. Quincy, IL 62305	http://thecrossing.net/	X	X	X	
Transitions of Western Illinois	Provides a comprehensive array of mental health, educational, and rehabilitation services.	217-223-0413	4409 Maine St. Quincy, IL 62305	http://twi.org/	X	X	X	
Two Rivers Regional Council	Services to low income families in Adams, Brown, Pike, and Schuyler Counties.	217-224-8171	1125 Hampshire St. Quincy, IL 62301	www.trrcopo.org	X	X	X	
United Way Help Line	Information & Referral	217-224-1223	936 Broadway St. Quincy, IL 62301	http://www.unitedwayadamsco.org/servlet/eAndar.article/1/Click-the-image-below-to-see-the-Stati	X	X	X	
Well House	Transitional housing	217-617-2312	701 Boradway St. Quincy, IL 62301	www.wellhouse.us		X		

Organization Name	Project Name / Service	Contact Phone	Address	Website	Men	Women	Families	Youth
West Central Child Care Connection	Accessable, affordable, and quality child care.	217-222-2550	510 Maine St. #610 Quincy, IL 62301	http://www.wcccc.com/	X	X	X	
YWCA	Permanent supportive housing	217-221-9922	639 York St. Suite 202 Quincy, IL 62301	http://www.ywcaquincy.org/site/c.djJULcNPJjL6H/b.9203611/k.BCEC/Home.htm		X	X	

Appendix C: WCICCC's Coordinated Assessment Tools

The WCICCC Coordinated Assessment Screening is made up of 3 parts that are used at different phases of coordinated assessment. In order to maintain a uniform assessment screening across the counties of the WCICCC, the assessment screening can only be modified as specified below beside MODIFICATIONS.

1. Emergency Response Screening

PURPOSE	Reduce entries into homeless system
WHEN TO ADMINISTER	Immediately, as applicants present themselves to enter the homeless service system
HOW TO ADMINISTER	Regional Committees will select an agency to complete screening in person and/or by phone as people initially access the homeless service system
TRAINING	Online training will be developed
MODIFICATIONS	None

2. Service Assessment & Prioritization Screening (VI-SPDAT and full SPDAT)

PURPOSE	Assign appropriate referral for client and prioritize which client will receive housing and services next
WHEN TO ADMINISTER	Within 72 hours after entering system
HOW TO ADMINISTER	Regional Committees will designate locations and staff to administer VI-SPDAT. If individuals or families qualify for medium or high intervention, then the full SPDAT will be used for prioritization purposes.
TRAINING	All users must complete free, online training
MODIFICATIONS	Coordinated Assessment Workgroup will provide guidelines for how the scoring will determine the type of program referrals. If a Regional Committee does not have a certain type of program, they can adjust these guidelines with the approval

3. Case Management Assessment (full SPDAT)

PURPOSE	Standardized tool for case management to track outcomes
WHEN TO ADMINISTER	Prior to housing, at or about move-in (no more than 3 business days after move-in), 30 days, 90 days, 180 days, 270 days, 365 days
HOW TO ADMINISTER	Housing programs will administer this tool to all participants
TRAINING	Online training will be developed
MODIFICATIONS	Provider can use the attached assessment or use their own assessment

Name:_____

Date: _____

WCICCC Emergency Response Screening

(Form Used by Shelter Providers and Providers Receiving Homeless Prevention & Rapid Rehousing Funds)

Name:_____ Phone:_____

1. **Are you homeless or do you believe you will become homeless in the next 72 hours?**
   __ Yes __ No
   HUD definition of homeless: living in a place not meant for human habitation, in emergency shelter (including domestic violence shelter), in transitional housing, or exiting an institution where they temporarily resided for up to 90 days and were in shelter or a place not meant for human habitation immediately prior to entering that institution.

2. **Are you currently residing with, or trying to leave, an intimate partner who threatens you or makes you fearful?**
   __ Yes __ No
   If no to Question 1 AND Question 2, refer to mainstream resources (Appendix B)

If yes to Question 2, refer to DV resources (Appendix B). If yes to Question 2, clients are referred to DV resources and DO NOT PROCEED WITH THIS ASSESSMENT or any part of the Coordinated Assessment process. If the client chooses declines referral to DV resource, then complete the rest of screening.

3. **Where did you sleep last night?** _____
4. **Was it a safe location?** __ Yes __ No
   If no, ask "What made the location unsafe?" "Is there another place you can think of where you feel safe and could stay for a couple of nights?"

PREVENTION/DIVERSION QUESTIONS

5. **Why did you have to leave the place you stayed last night?** _____

6. **Could you stay tonight at the same location?** __ Yes __ No
   If no, skip to Question 6

   a. **What would you need to help you stay where you stayed last night again?**
   __ Landlord mediation
   __ Conflict resolution
   __ Rental assistance (Amount: $_____)
   __ Utility assistance (Amount: $_____)
   __ Other financial assistance (Amount: $_____)
   __ Other assistance (Please describe:_____)

Name:_____

Date: _____

b. Would it help if I contacted the person you stayed with? What is the best way to contact that person?

Name _____Phone_____

Contact date(s) and result _____

7. Is there anyone else you (and your family) could stay with? Friends, family, co-workers?

Yes No

If no, skip to Question 7

a. What would you need to help you stay there?

_____Landlord mediation

_____Conflict resolution

_____Rental assistance (Amount: $ _)

_____Utility assistance (Amount: $ _)

_____Other financial assistance (Amount: $)

_____Other assistance (Please describe:_____)

b. Would it help if I contacted someone you can stay with? What is the best way to contact that person?

Name _____Phone_____

Contact date(s) and result _____

8. Is the assistance needed to prevent or divert this household from entering the homeless system available in your community?

__ Yes __ No

9. If no, what was the result of this screening process for this household?

___ Referred to shelter ___Referred to DV program ___Received hotel/motel voucher

___No assistance given ___Referred to Transitional Housing ___Other

If household is not appropriate for prevention and diversion referral, at this point household members are referred to local emergency response programs. Each Regional Committee will determine referral eligibility questions based upon what is available in the community.

Screening Completed By_____

Agency Site: _____

Vulnerability Index -

Service Prioritization Decision Assistance Tool

(VI-SPDAT)

Prescreen Triage Tool for Single Adults

AMERICAN VERSION 2.0

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

COMMUNITY SOLUTIONS

ORG CODE

Welcome to the SPDAT Line of Products

The Service Prioritization Decision Assistance Tool (SPDAT) has been around in various incarnations for over a decade, before being released to the public in 2010. Since its initial release, the use of the SPDAT has been expanding exponentially and is now used in over one thousand communities across the United States, Canada, and Australia.

More communities using the tool means there is an unprecedented demand for versions of the SPDAT, customized for specific client groups or types of users. With the release of SPDAT V4, there have been more current versions of SPDAT products than ever before.

VI-SPDAT Series

The Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) was developed as a pre-screening tool for communities that are very busy and do not have the resources to conduct a full SPDAT assessment for every client. It was made in collaboration with Community Solutions, creators of the Vulnerability Index, as a brief survey that can be conducted to quickly determine whether a client has high, moderate, or low acuity. The use of this survey can help prioritize which clients should be given a full SPDAT assessment first. Because it is a self-reported survey, no special training is required to use the VI-SPDAT.

Current versions available:

- VI-SPDAT V 2.0 for Individuals
- VI-SPDAT V 2.0 for Families
- VI-SPDAT V 1.0 for Youth

All versions are available online at

www.orgcode.com/products/vi-spdat/

SPDAT Series

The Service Prioritization Decision Assistance Tool (SPDAT) was developed as an assessment tool for front-line workers at agencies that work with homeless clients to prioritize which of those clients should receive assistance first. The SPDAT tools are also designed to help guide case management and improve housing stability outcomes. They provide an in-depth assessment that relies on the assessor's ability to interpret responses and corroborate those with evidence. As a result, this tool may only be used by those who have received proper, up-to-date training provided by OrgCode Consulting, Inc. or an OrgCode certified trainer.

Current versions available:

- SPDAT V 4.0 for Individuals
- SPDAT V 2.0 for Families
- SPDAT V 1.0 for Youth

Information about all versions is available online at

www.orgcode.com/products/spdat/

SPDAT Training Series

To use the SPDAT, training by OrgCode or an OrgCode certified trainer is required. We provide training on a wide variety of topics over a variety of mediums.

The full-day in-person SPDAT Level 1 training provides you the opportunity to bring together as many people as you want to be trained for one low fee. The webinar training allows for a maximum of 15 different computers to be logged into the training at one time. We also offer online courses for individuals that you can do at your own speed.

The training gives you the manual, case studies, application to current practice, a review of each component of the tool, conversation guidance with prospective clients – and more!

Current SPDAT training available:

- Level 0 SPDAT Training: VI-SPDAT for Frontline Workers
- Level 1 SPDAT Training: SPDAT for Frontline Workers
- Level 2 SPDAT Training: SPDAT for Supervisors
- Level 3 SPDAT Training: SPDAT for Trainers

Other related training available:

- Excellence in Housing-Based Case Management
- Coordinated Access & Common Assessment
- Motivational Interviewing
- Objective-Based Interactions

More information about SPDAT training, including pricing, is available online at

http://www.orgcode.com/product-category/training/spdat/

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:**

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	RESULTS
PRE-SURVEY	/1	**Score: Recommendation:**
A. HISTORY OF HOUSING & HOMELESSNESS	/2	0-3: no housing intervention
B. RISKS	/4	4-7: an assessment for Rapid Re-Housing
C. SOCIALIZATION & DAILY FUNCTIONS	/4	8+: an assessment for Permanent Supportive Housing/Housing First
D. WELLNESS	/6	
GRAND TOTAL:	/17	

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

Appendix A: About the VI-SPDAT

The HEARTH Act and federal regulations require communities to have an assessment tool for coordinated entry - and the VI-SPDAT and SPDAT meet these requirements. Many communities have struggled to comply with this requirement, which demands an investment of considerable time, resources and expertise. Others are making it up as they go along, using "gut instincts" in lieu of solid evidence. Communities need practical, evidence-informed tools that enhance their ability to to satisfy federal regulations and quickly implement an effective approach to access and assessment. The VI-SPDAT is a first-of-its-kind tool designed to fill this need, helping communities end homelessness in a quick, strategic fashion.

The VI-SPDAT

The VI-SPDAT was initially created by combining the elements of the Vulnerability Index which was created and implemented by Community Solutions broadly in the 100,000 Homes Campaign, and the SPDAT Prescreen Instrument that was part of the Service Prioritization Decision Assistance Tool. The combination of these two instruments was performed through extensive research and development, and testing. The development process included the direct voice of hundreds of persons with lived experience.

The VI-SPDAT examines factors of current vulnerability and future housing stability. It follows the structure of the SPDAT assessment tool, and is informed by the same research backbone that supports the SPDAT - almost 300 peer reviewed published journal articles, government reports, clinical and quasi-clinical assessment tools, and large data sets. The SPDAT has been independently tested, as well as internally reviewed. The data overwhelmingly shows that when the SPDAT is used properly, housing outcomes are better than when no assessment tool is used.

The VI-SPDAT is a triage tool. It highlights areas of higher acuity, thereby helping to inform the type of support and housing intervention that may be most beneficial to improve long term housing outcomes. It also helps inform the order - or priority - in which people should be served. The VI-SPDAT does not make decisions; it informs decisions. The VI-SPDAT provides data that communities, service providers, and people experiencing homelessness can use to help determine the best course of action next.

Version 2

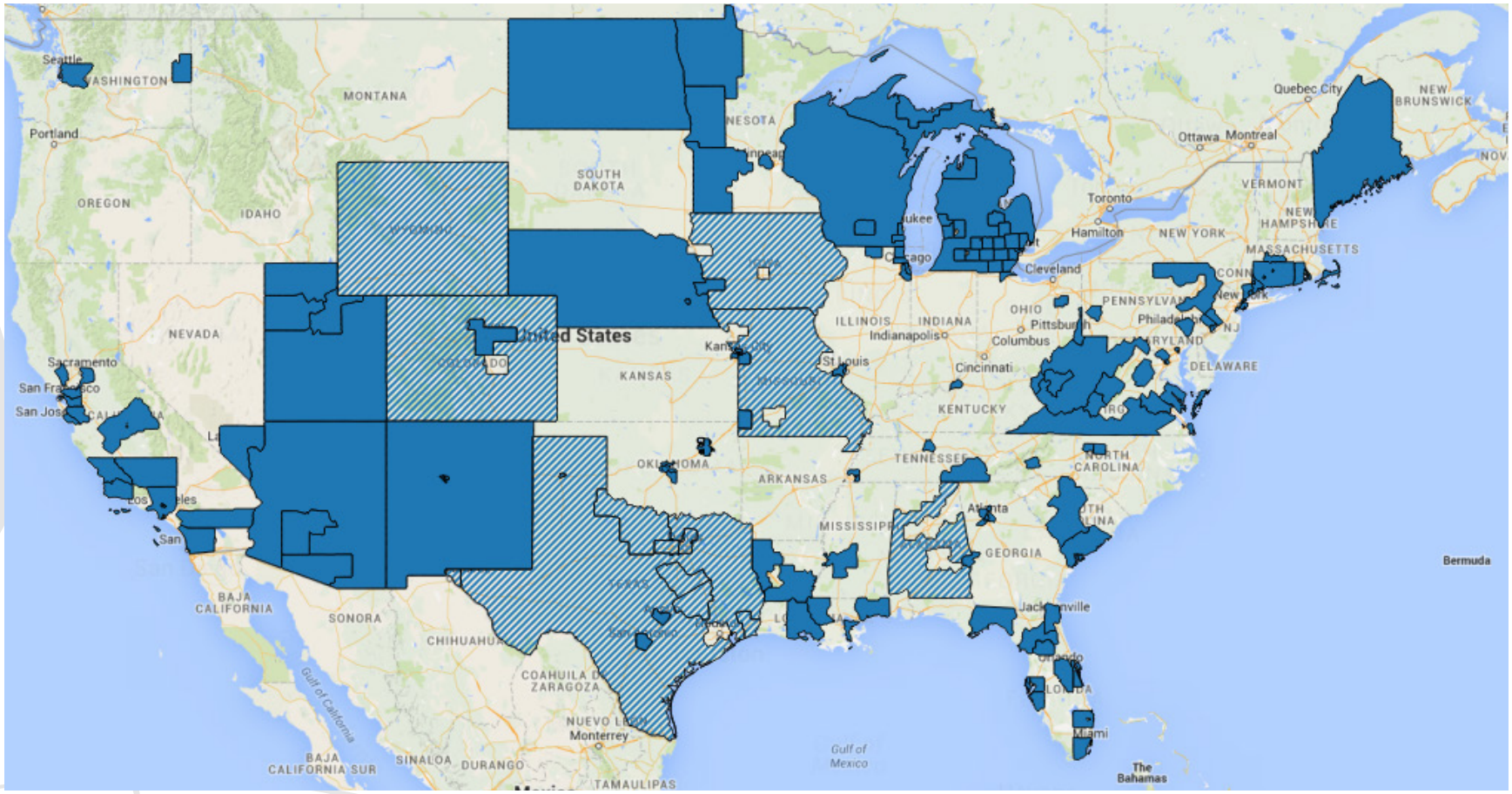
Version 2 builds upon the success of Version 1 of the VI-SPDAT with some refinements. Starting in August 2014, a survey was launched of existing VI-SPDAT users to get their input on what should be amended, improved, or maintained in the tool. Analysis was completed across all of these responses. Further research was conducted. Questions were tested and refined over several months, again including the direct voice of persons with lived experience and frontline practitioners. Input was also gathered from senior government officials that create policy and programs to help ensure alignment with guidelines and funding requirements.

You will notice some differences in Version 2 compared to Version 1. Namely:

- it is shorter, usually taking less than 7 minutes to complete;
- subjective elements through observation are now gone, which means the exact same instrument can be used over the phone or in-person;
- medical, substance use, and mental health questions are all refined;
- you can now explicitly see which component of the full SPDAT each VI-SPDAT question links to; and,
- the scoring range is slightly different (Don't worry, we can provide instructions on how these relate to results from Version 1).

Appendix B: Where the VI-SPDAT is being used in the United States

Since the VI-SPDAT is provided completely free of charge, and no training is required, any community is able to use the VI-SPDAT without the explicit permission of Community Solutions or OrgCode Consulting, Inc. As a result, the VI-SPDAT is being used in more communities than we know of. It is also being used in Canada and Australia.



A partial list of continua of care (CoCs) in the US where we know the VI-SPDAT is being used includes:

Alabama
- Parts of Alabama Balance of State

Arizona
- Statewide

California
- San Jose/Santa Clara City & County
- San Francisco
- Oakland/Alameda County
- Sacramento City & County
- Richmond/Contra Costa County
- Watsonville/Santa Cruz City & County
- Fresno/Madera County
- Napa City & County
- Los Angeles City & County
- San Diego
- Santa Maria/Santa Barbara County
- Bakersfield/Kern County
- Pasadena
- Riverside City & County
- Glendale
- San Luis Obispo County

Colorado
- Metropolitan Denver Homeless Initiative
- Parts of Colorado Balance of State

Connecticut
- Hartford
- Bridgeport/Stratford/Fairfield
- Connecticut Balance of State
- Norwalk/Fairfield County
- Stamford/Greenwich
- City of Waterbury

District of Columbia
- District of Columbia

Florida
- Sarasota/Bradenton/Manatee, Sarasota Counties
- Tampa/Hillsborough County
- St. Petersburg/Clearwater/Largo/Pinellas County
- Tallahassee/Leon County
- Orlando/Orange, Osceola, Seminole Counties
- Gainesville/Alachua, Putnam Counties
- Jacksonville-Duval, Clay Counties
- Palm Bay/Melbourne/Brevard County
- Ocala/Marion County
- Miami/Dade County
- West Palm Beach/Palm Beach County

Georgia
- Atlanta County
- Fulton County
- Columbus-Muscogee/Russell County
- Marietta/Cobb County
- DeKalb County

Hawaii
- Honolulu

Illinois
- Rockford/Winnebago, Boone Counties
- Waukegan/North Chicago/Lake County
- Chicago
- Cook County

Iowa
- Parts of Iowa Balance of State

Kansas
- Kansas City/Wyandotte County

Kentucky
- Louisville/Jefferson County

Louisiana
- Lafayette/Acadiana
- Shreveport/Bossier/Northwest
- New Orleans/Jefferson Parish
- Baton Rouge
- Alexandria/Central Louisiana CoC

Massachusetts
- Cape Cod Islands
- Springfield/Holyoke/Chicopee/Westfield/Hampden County

Maryland
- Baltimore City
- Montgomery County

Maine
- Statewide

Michigan
- Statewide

Minnesota
- Minneapolis/Hennepin County
- Northwest Minnesota
- Moorhead/West Central Minnesota
- Southwest Minnesota

Missouri
- St. Louis County
- St. Louis City
- Joplin/Jasper, Newton Counties
- Kansas City/Independence/Lee's Summit/Jackson County
- Parts of Missouri Balance of State

Mississippi
- Jackson/Rankin, Madison Counties
- Gulf Port/Gulf Coast Regional

North Carolina
- Winston Salem/Forsyth County
- Asheville/Buncombe County
- Greensboro/High Point

North Dakota
- Statewide

Nebraska
- Statewide

New Mexico
- Statewide

Nevada
- Las Vegas/Clark County

New York
- New York City
- Yonkers/Mount Vernon/New Rochelle/Westchester County

Ohio
- Toledo/Lucas County
- Canton/Massillon/Alliance/Stark County

Oklahoma
- Tulsa City & County/Broken Arrow
- Oklahoma City
- Norman/Cleveland County

Pennsylvania
- Philadelphia
- Lower Marion/Norristown/Abington/Montgomery County
- Allentown/Northeast Pennsylvania
- Lancaster City & County
- Bristol/Bensalem/Bucks County
- Pittsburgh/McKeesport/Penn Hills/Allegheny County

Rhode Island
- Statewide

South Carolina
- Charleston/Low Country
- Columbia/Midlands

Tennessee
- Chattanooga/Southeast Tennessee
- Memphis/Shelby County
- Nashville/Davidson County

Texas
- San Antonio/Bexar County
- Austin/Travis County
- Dallas City & County/Irving
- Fort Worth/Arlington/Tarrant County
- El Paso City and County
- Waco/McLennan County
- Texas Balance of State
- Amarillo
- Wichita Falls/Wise, Palo Pinto, Wichita, Archer Counties
- Bryan/College Station/Brazos Valley
- Beaumont/Port Arthur/South East Texas

Utah
- Statewide

Virginia
- Richmond/Henrico, Chesterfield, Hanover Counties
- Roanoke City & County/Salem
- Virginia Beach
- Portsmouth
- Virginia Balance of State
- Arlington County

Washington
- Seattle/King County
- Spokane City & County

Wisconsin
- Statewide

West Virginia
- Statewide

Wyoming
- Wyoming Statewide is in the process of implementing

Vulnerability Index -

Service Prioritization Decision Assistance Tool

(VI-SPDAT)

Prescreen Triage Tool for Families

AMERICAN VERSION 2.0

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

COMMUNITY SOLUTIONS

ORG CODE

Welcome to the SPDAT Line of Products

The Service Prioritization Decision Assistance Tool (SPDAT) has been around in various incarnations for over a decade, before being released to the public in 2010. Since its initial release, the use of the SPDAT has been expanding exponentially and is now used in over one thousand communities across the United States, Canada, and Australia.

More communities using the tool means there is an unprecedented demand for versions of the SPDAT, customized for specific client groups or types of users. With the release of SPDAT V4, there have been more current versions of SPDAT products than ever before.

VI-SPDAT Series

The Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) was developed as a pre-screening tool for communities that are very busy and do not have the resources to conduct a full SPDAT assessment for every client. It was made in collaboration with Community Solutions, creators of the Vulnerability Index, as a brief survey that can be conducted to quickly determine whether a client has high, moderate, or low acuity. The use of this survey can help prioritize which clients should be given a full SPDAT assessment first. Because it is a self-reported survey, no special training is required to use the VI-SPDAT.

Current versions available:

- VI-SPDAT V 2.0 for Individuals
- VI-SPDAT V 2.0 for Families
- VI-SPDAT V 1.0 for Youth

All versions are available online at

www.orgcode.com/products/vi-spdat/

SPDAT Series

The Service Prioritization Decision Assistance Tool (SPDAT) was developed as an assessment tool for front-line workers at agencies that work with homeless clients to prioritize which of those clients should receive assistance first. The SPDAT tools are also designed to help guide case management and improve housing stability outcomes. They provide an in-depth assessment that relies on the assessor's ability to interpret responses and corroborate those with evidence. As a result, this tool may only be used by those who have received proper, up-to-date training provided by OrgCode Consulting, Inc. or an OrgCode certified trainer.

Current versions available:

- SPDAT V 4.0 for Individuals
- SPDAT V 2.0 for Families
- SPDAT V 1.0 for Youth

Information about all versions is available online at

www.orgcode.com/products/spdat/

SPDAT Training Series

To use the SPDAT, training by OrgCode or an OrgCode certified trainer is required. We provide training on a wide variety of topics over a variety of mediums.

The full-day in-person SPDAT Level 1 training provides you the opportunity to bring together as many people as you want to be trained for one low fee. The webinar training allows for a maximum of 15 different computers to be logged into the training at one time. We also offer online courses for individuals that you can do at your own speed.

The training gives you the manual, case studies, application to current practice, a review of each component of the tool, conversation guidance with prospective clients – and more!

Current SPDAT training available:

- Level 0 SPDAT Training: VI-SPDAT for Frontline Workers
- Level 1 SPDAT Training: SPDAT for Frontline Workers
- Level 2 SPDAT Training: SPDAT for Supervisors
- Level 3 SPDAT Training: SPDAT for Trainers

Other related training available:

- Excellence in Housing-Based Case Management
- Coordinated Access & Common Assessment
- Motivational Interviewing
- Objective-Based Interactions

More information about SPDAT training, including pricing, is available online at

http://www.orgcode.com/product-category/training/spdat/

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 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

PARENT 1

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

PARENT 2

☐ No second parent currently part of the household

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 EITHER HEAD OF HOUSEHOLD IS 60 YEARS OF AGE OR OLDER, THEN SCORE 1.

SCORE:

Children

1. How many children under the age of 18 are currently with you? _____ ☐ Refused
2. How many children under the age of 18 are not currently with your family, but you have reason to believe they will be joining you when you get housed? _____ ☐ Refused
3. *IF HOUSEHOLD INCLUDES A FEMALE:* Is any member of the family currently pregnant? ☐ **Y** ☐ N ☐ Refused
4. Please provide a list of children's names and ages:

First Name	Last Name	Age	Date of Birth

IF THERE IS A SINGLE PARENT WITH 2+ CHILDREN, AND/OR A CHILD AGED 11 OR YOUNGER, AND/OR A CURRENT PREGNANCY, THEN SCORE 1 FOR **FAMILY SIZE**.

IF THERE ARE TWO PARENTS WITH 3+ CHILDREN, AND/OR A CHILD AGED 6 OR YOUNGER, AND/OR A CURRENT PREGNANCY, THEN SCORE 1 FOR **FAMILY SIZE**.

SCORE:

A. History of Housing and Homelessness

5. Where do you and your family 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:

6. How long has it been since you and your family lived in permanent stable housing? _____ ☐ Refused
7. In the last three years, how many times have you and your family been homeless? _____ ☐ Refused

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

SCORE:

B. Risks

8. In the past six months, how many times have you or anyone in your family...

   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 they witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told them that they 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:**

9. Have you or anyone in your family been attacked or beaten up since they've become homeless? ☐ **Y** ☐ N ☐ Refused

10. Have you or anyone in your family threatened to or tried to harm themself 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:**

11. Do you or anyone in your family have any legal stuff going on right now that may result in them 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:**

12. Does anybody force or trick you or anyone in your family to do things that you do not want to do? ☐ **Y** ☐ N ☐ Refused

13. Do you or anyone in your family ever do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone they 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

14.	Is there any person, past landlord, business, bookie, dealer, or government group like the IRS that thinks you or anyone in your family owe them money?	☐ **Y**	☐ N	☐ Refused
15.	Do you or anyone in your family 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 14 OR "NO" TO QUESTION 15, THEN SCORE 1 FOR **MONEY MANAGEMENT.** **SCORE:**

16.	Does everyone in your family have planned activities, other than just surviving, that make them feel happy and fulfilled?	☐ Y	☐ **N**	☐ Refused

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

17.	Is everyone in your family 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:**

18.	Is your family's current homelessness in any way caused by a relationship that broke down, an unhealthy or abusive relationship, or because other family or friends caused your family to become evicted?	☐ **Y**	☐ N	☐ Refused

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

D. Wellness

19.	Has your family ever had to leave an apartment, shelter program, or other place you were staying because of the physical health of you or anyone in your family?	☐ **Y**	☐ N	☐ Refused
20.	Do you or anyone in your family have any chronic health issues with your liver, kidneys, stomach, lungs or heart?	☐ **Y**	☐ N	☐ Refused
21.	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 or anyone in your family?	☐ **Y**	☐ N	☐ Refused
22.	Does anyone in your family 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
23.	When someone in your family is sick or not feeling well, does your family avoid getting medical help?	☐ **Y**	☐ N	☐ Refused

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

24. Has drinking or drug use by you or anyone in your family led your family to being kicked out of an apartment or program where you were staying in the past?	☐ **Y**	☐ N	☐ Refused	
25. Will drinking or drug use make it difficult for your family to stay housed or afford your housing?	☐ **Y**	☐ N	☐ Refused	
IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **SUBSTANCE USE.**				**SCORE:**
26. Has your family 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	
27. Do you or anyone in your family have any mental health or brain issues that would make it hard for your family to live independently because help would be needed?	☐ **Y**	☐ N	☐ Refused	
IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **MENTAL HEALTH.**				**SCORE:**
28. *IF THE FAMILY SCORED 1 EACH FOR PHYSICAL HEALTH, SUBSTANCE USE, AND MENTAL HEALTH:* Does any single member of your household have a medical condition, mental health concerns, **and** experience with problematic substance use?	☐ **Y**	☐ N	☐ N/A or Refused	
IF "YES", SCORE 1 FOR **TRI-MORBIDITY**.				**SCORE:**
29. Are there any medications that a doctor said you or anyone in your family should be taking that, for whatever reason, they are not taking?	☐ **Y**	☐ N	☐ Refused	
30. Are there any medications like painkillers that you or anyone in your family don't take the way the doctor prescribed or where they sell the medication?	☐ **Y**	☐ N	☐ Refused	
IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR **MEDICATIONS.**				**SCORE:**
31. *YES OR NO:* Has your family's 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 or anyone in your family have experienced?	☐ **Y**	☐ N	☐ Refused	
IF "YES", SCORE 1 FOR **ABUSE AND TRAUMA.**				**SCORE:**

E. Family Unit

32.	Are there any children that have been removed from the family by a child protection service within the last 180 days?	☐ **Y**	☐ N	☐ Refused
33.	Do you have any family legal issues that are being resolved in court or need to be resolved in court that would impact your housing or who may live within your housing?	☐ **Y**	☐ N	☐ Refused

IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR **FAMILY LEGAL ISSUES.** **SCORE:**

34.	In the last 180 days have any children lived with family or friends because of your homelessness or housing situation?	☐ **Y**	☐ N	☐ Refused
35.	Has any child in the family experienced abuse or trauma in the last 180 days?	☐ **Y**	☐ N	☐ Refused
36.	*IF THERE ARE SCHOOL-AGED CHILDREN:* Do your children attend school more often than not each week?	☐ Y	☐ **N**	☐ N/A or Refused

IF "YES" TO ANY OF QUESTIONS 34 OR 35, OR "NO" TO QUESTION 36, SCORE 1 FOR **NEEDS OF CHILDREN.** **SCORE:**

37.	Have the members of your family changed in the last 180 days, due to things like divorce, your kids coming back to live with you, someone leaving for military service or incarceration, a relative moving in, or anything like that?	☐ **Y**	☐ N	☐ Refused
38.	Do you anticipate any other adults or children coming to live with you within the first 180 days of being housed?	☐ **Y**	☐ N	☐ Refused

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

39.	Do you have two or more planned activities each week as a family such as outings to the park, going to the library, visiting other family, watching a family movie, or anything like that?	☐ Y	☐ **N**	☐ Refused
40.	After school, or on weekends or days when there isn't school, is the total time children spend each day where there is no interaction with you or another responsible adult...			
	a) 3 or more hours per day for children aged 13 or older?	☐ **Y**	☐ N	☐ Refused
	b) 2 or more hours per day for children aged 12 or younger?	☐ **Y**	☐ N	☐ Refused
41.	*IF THERE ARE CHILDREN BOTH 12 AND UNDER & 13 AND OVER:* Do your older kids spend 2 or more hours on a typical day helping their younger sibling(s) with things like getting ready for school, helping with homework, making them dinner, bathing them, or anything like that?	☐ **Y**	☐ N	☐ N/A or Refused

IF "NO" TO QUESTION 39, OR "YES" TO ANY OF QUESTIONS 40 OR 41, SCORE 1 FOR **PARENTAL ENGAGEMENT.** **SCORE:**

Scoring Summary

DOMAIN	SUBTOTAL
PRE-SURVEY	/2
A. HISTORY OF HOUSING & HOMELESSNESS	/2
B. RISKS	/4
C. SOCIALIZATION & DAILY FUNCTIONS	/4
D. WELLNESS	/6
E. FAMILY UNIT	/4
GRAND TOTAL:	/22

RESULTS

Score:	Recommendation:
0-3	no housing intervention
4-8	an assessment for Rapid Re-Housing
9+	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

Appendix A: About the VI-SPDAT

The HEARTH Act and federal regulations require communities to have an assessment tool for coordinated entry - and the VI-SPDAT and SPDAT meet these requirements. Many communities have struggled to comply with this requirement, which demands an investment of considerable time, resources and expertise. Others are making it up as they go along, using "gut instincts" in lieu of solid evidence. Communities need a practical, evidence-informed way to satisfy federal regulations while quickly implementing an effective approach to access and assessment. The VI-SPDAT is a first-of-its-kind tool designed to fill this need, helping communities end homelessness in a quick, strategic fashion.

The VI-SPDAT

The VI-SPDAT was initially created by combining the elements of the Vulnerability Index which was created and implemented by Community Solutions broadly in the 100,000 Homes Campaign, and the SPDAT Prescreen Instrument that was part of the Service Prioritization Decision Assistance Tool. The combination of these two instruments was performed through extensive research and development, and testing. The development process included the direct voice of hundreds of persons with lived experience.

The VI-SPDAT examines factors of current vulnerability and future housing stability. It follows the structure of the SPDAT assessment tool, and is informed by the same research backbone that supports the SPDAT - almost 300 peer reviewed published journal articles, government reports, clinical and quasi-clinical assessment tools, and large data sets. The SPDAT has been independently tested, as well as internally reviewed. The data overwhelmingly shows that when the SPDAT is used properly, housing outcomes are better than when no assessment tool is used.

The VI-SPDAT is a triage tool. It highlights areas of higher acuity, thereby helping to inform the type of support and housing intervention that may be most beneficial to improve long term housing outcomes. It also helps inform the order - or priority - in which people should be served. The VI-SPDAT does not make decisions; it informs decisions. The VI-SPDAT provides data that communities, service providers, and people experiencing homelessness can use to help determine the best course of action next.

Version 2

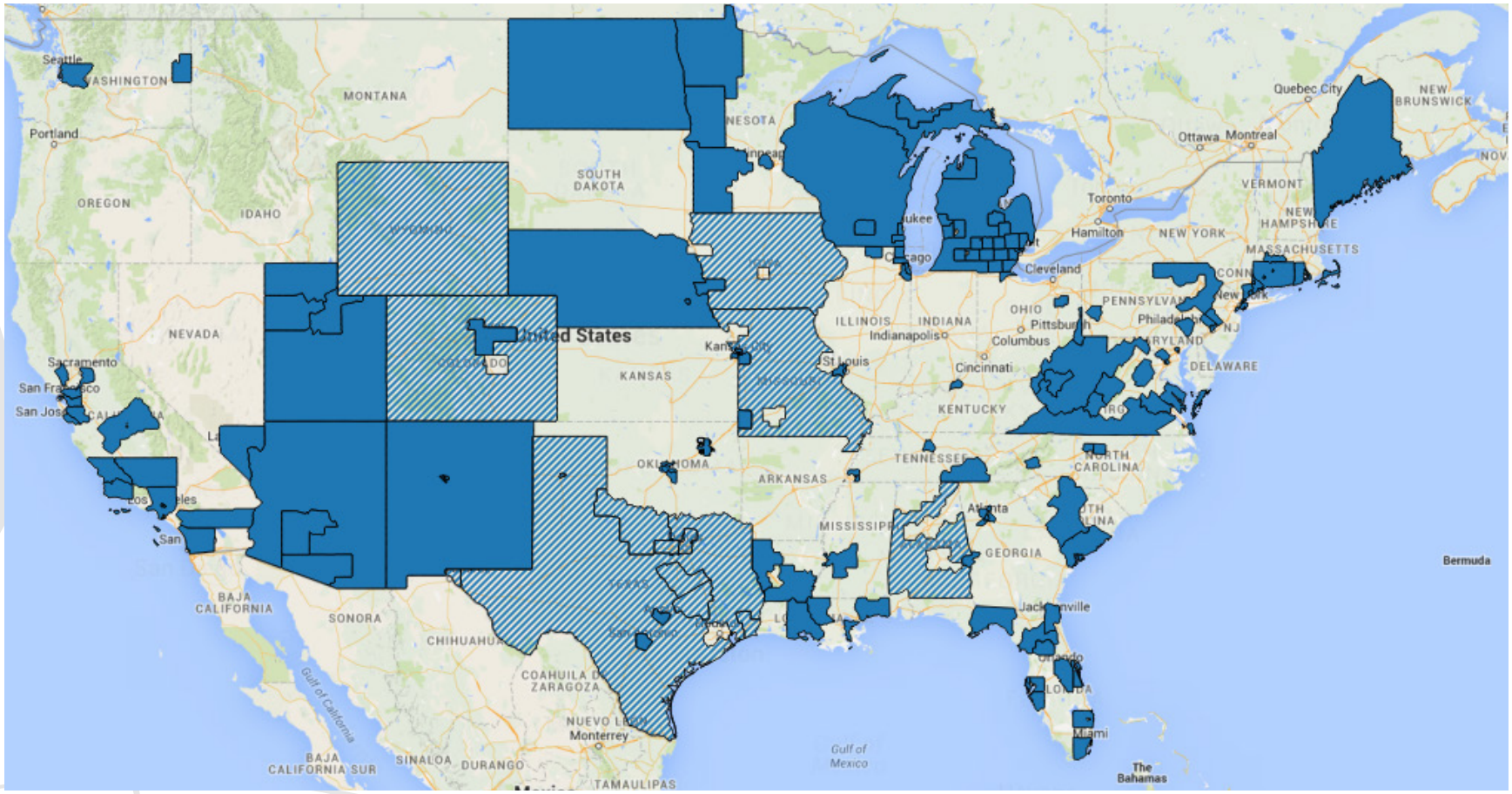
Version 2 builds upon the success of Version 1 of the VI-SPDAT with some refinements. Starting in August 2014, a survey was launched of existing VI-SPDAT users to get their input on what should be amended, improved, or maintained in the tool. Analysis was completed across all of these responses. Further research was conducted. Questions were tested and refined over several months, again including the direct voice of persons with lived experience and frontline practitioners. Input was also gathered from senior government officials that create policy and programs to help ensure alignment with guidelines and funding requirements.

You will notice some differences in Version 2 compared to Version 1. Namely:

- it is shorter, usually taking less than 7 minutes to complete;
- subjective elements through observation are now gone, which means the exact same instrument can be used over the phone or in-person;
- medical, substance use, and mental health questions are all refined;
- you can now explicitly see which component of the full SPDAT each VI-SPDAT question links to; and,
- the scoring range is slightly different (Don't worry, we can provide instructions on how these relate to results from Version 1).

Appendix B: Where the VI-SPDAT is being used in the United States

Since the VI-SPDAT is provided completely free of charge, and no training is required, any community is able to use the VI-SPDAT without the explicit permission of Community Solutions or OrgCode Consulting, Inc. As a result, the VI-SPDAT is being used in more communities than we know of. It is also being used in Canada and Australia.



A partial list of continua of care (CoCs) in the US where we know the VI-SPDAT is being used includes:

Alabama
- Parts of Alabama Balance of State

Arizona
- Statewide

California
- San Jose/Santa Clara City & County
- San Francisco
- Oakland/Alameda County
- Sacramento City & County
- Richmond/Contra Costa County
- Watsonville/Santa Cruz City & County
- Fresno/Madera County
- Napa City & County
- Los Angeles City & County
- San Diego
- Santa Maria/Santa Barbara County
- Bakersfield/Kern County
- Pasadena
- Riverside City & County
- Glendale
- San Luis Obispo County

Colorado
- Metropolitan Denver Homeless Initiative
- Parts of Colorado Balance of State

Connecticut
- Hartford
- Bridgeport/Stratford/Fairfield
- Connecticut Balance of State
- Norwalk/Fairfield County
- Stamford/Greenwich
- City of Waterbury

District of Columbia
- District of Columbia

Florida
- Sarasota/Bradenton/Manatee, Sarasota Counties
- Tampa/Hillsborough County
- St. Petersburg/Clearwater/Largo/Pinellas County
- Tallahassee/Leon County
- Orlando/Orange, Osceola, Seminole Counties
- Gainesville/Alachua, Putnam Counties
- Jacksonville-Duval, Clay Counties
- Palm Bay/Melbourne/Brevard County
- Ocala/Marion County
- Miami/Dade County
- West Palm Beach/Palm Beach County

Georgia
- Atlanta County
- Fulton County
- Columbus-Muscogee/Russell County
- Marietta/Cobb County
- DeKalb County

Hawaii
- Honolulu

Illinois
- Rockford/Winnebago, Boone Counties
- Waukegan/North Chicago/Lake County
- Chicago
- Cook County

Iowa
- Parts of Iowa Balance of State

Kansas
- Kansas City/Wyandotte County

Kentucky
- Louisville/Jefferson County

Louisiana
- Lafayette/Acadiana
- Shreveport/Bossier/Northwest
- New Orleans/Jefferson Parish
- Baton Rouge
- Alexandria/Central Louisiana CoC

Massachusetts
- Cape Cod Islands
- Springfield/Holyoke/Chicopee/Westfield/Hampden County

Maryland
- Baltimore City
- Montgomery County

Maine
- Statewide

Michigan
- Statewide

Minnesota
- Minneapolis/Hennepin County
- Northwest Minnesota
- Moorhead/West Central Minnesota
- Southwest Minnesota

Missouri
- St. Louis County
- St. Louis City
- Joplin/Jasper, Newton Counties
- Kansas City/Independence/Lee's Summit/Jackson County
- Parts of Missouri Balance of State

Mississippi
- Jackson/Rankin, Madison Counties
- Gulf Port/Gulf Coast Regional

North Carolina
- Winston Salem/Forsyth County
- Asheville/Buncombe County
- Greensboro/High Point

North Dakota
- Statewide

Nebraska
- Statewide

New Mexico
- Statewide

Nevada
- Las Vegas/Clark County

New York
- New York City
- Yonkers/Mount Vernon/New Rochelle/Westchester County

Ohio
- Toledo/Lucas County
- Canton/Massillon/Alliance/Stark County

Oklahoma
- Tulsa City & County/Broken Arrow
- Oklahoma City
- Norman/Cleveland County

Pennsylvania
- Philadelphia
- Lower Marion/Norristown/Abington/Montgomery County
- Allentown/Northeast Pennsylvania
- Lancaster City & County
- Bristol/Bensalem/Bucks County
- Pittsburgh/McKeesport/Penn Hills/Allegheny County

Rhode Island
- Statewide

South Carolina
- Charleston/Low Country
- Columbia/Midlands

Tennessee
- Chattanooga/Southeast Tennessee
- Memphis/Shelby County
- Nashville/Davidson County

Texas
- San Antonio/Bexar County
- Austin/Travis County
- Dallas City & County/Irving
- Fort Worth/Arlington/Tarrant County
- El Paso City and County
- Waco/McLennan County
- Texas Balance of State
- Amarillo
- Wichita Falls/Wise, Palo Pinto, Wichita, Archer Counties
- Bryan/College Station/Brazos Valley
- Beaumont/Port Arthur/South East Texas

Utah
- Statewide

Virginia
- Richmond/Henrico, Chesterfield, Hanover Counties
- Roanoke City & County/Salem
- Virginia Beach
- Portsmouth
- Virginia Balance of State
- Arlington County

Washington
- Seattle/King County
- Spokane City & County

Wisconsin
- Statewide

West Virginia
- Statewide

Wyoming
- Wyoming Statewide is in the process of implementing

Service Prioritization Decision Assistance Tool

(SPDAT)

Assessment Tool for Single Adults

VERSION 4.01

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

Welcome to the SPDAT Line of Products

The Service Prioritization Decision Assistance Tool (SPDAT) has been around in various incarnations for over a decade, before being released to the public in 2010. Since its initial release, the use of the SPDAT has been expanding exponentially and is now used in over one thousand communities across the United States, Canada, and Australia.

More communities using the tool means there is an unprecedented demand for versions of the SPDAT, customized for specific client groups or service delivery contexts. With the release of SPDAT V4, there have been more current versions of SPDAT products than ever before.

VI-SPDAT Series

The **Vulnerability Index – Service Prioritization Decision Assistance Tool** (VI-SPDAT) was developed as a pre-screening tool for communities that are very busy and may not have the resources to conduct a full SPDAT assessment for every client. It was made in collaboration with Community Solutions, creators of the Vulnerability Index, as a brief survey that can be conducted to quickly determine whether a client has high, moderate, or low acuity. The use of this survey can help prioritize which clients should be given a full SPDAT assessment first. Because it is a self-reported survey, no special training is required to use the VI-SPDAT.

Current versions available:

- VI-SPDAT V 2.0 for Individuals
- VI-SPDAT V 2.0 for Families
- VI-SPDAT V 1.0 for Youth

All versions are available online at

www.orgcode.com/products/vi-spdat/

SPDAT Series

The **Service Prioritization Decision Assistance Tool** (SPDAT) was developed as an assessment tool for frontline workers at agencies that work with homeless clients to prioritize which of those clients should receive assistance first. It is an in-depth assessment that relies on the assessor's ability to interpret responses and corroborate those with evidence. As a result, this tool may only be used by those who have received proper, up-to-date training provided by OrgCode Consulting, Inc. or an OrgCode certified trainer.

Current versions available:

- SPDAT V 4.0 for Individuals
- SPDAT V 2.0 for Families
- SPDAT V 1.0 for Youth

Information about all versions is available online at

www.orgcode.com/products/spdat/

SPDAT Training Series

To use the SPDAT, training by OrgCode or an OrgCode certified trainer is required. We provide training on a wide variety of topics over a variety of mediums.

The full-day in-person SPDAT Level 1 training provides you the opportunity to bring together as many people as you want to be trained for one low fee. The webinar training allows for a maximum of 15 different computers to be logged into the training at one time. We also offer online courses for individuals that you can do at your own speed.

The training gives you the manual, case studies, application to current practice, a review of each component of the tool, conversation guidance with prospective clients – and more!

Current SPDAT training available:

- Level 0 SPDAT Training: VI-SPDAT for Frontline Workers
- Level 1 SPDAT Training: SPDAT for Frontline Workers
- Level 2 SPDAT Training: SPDAT for Supervisors
- Level 3 SPDAT Training: SPDAT for Trainers

Other related training available:

- Excellence in Housing-Based Case Management
- Coordinated Access & Common Assessment
- Motivational Interviewing
- Objective-Based Interactions

More information about SPDAT training, including pricing, is available online at

http://www.orgcode.com/product-category/training/spdat/

Terms and Conditions Governing the Use of the SPDAT

SPDAT products have been developed by OrgCode Consulting, Inc. with extensive feedback from key community partners including people with lived experience. The tools are provided free of charge to communities to improve the client centered services dedicated to increasing housing stability and wellness. Training is indeed required for the administration and interpretation of these assessment tools. Use of the SPDAT products without authorized training is strictly prohibited.

By using this tool, you accept and agree to be bound by the terms of this expectation.

No sharing, reproduction, use or duplication of the information herein is permitted without the express written consent of OrgCode Consulting, Inc.

Ownership

The Service Prioritization Decision Assistance Tool ("SPDAT") and accompanying documentation is owned by OrgCode Consulting, Inc.

Training

Although the SPDAT Series is provided free of charge to communities, training by OrgCode Consulting, Inc. or a third party trainer, authorized by OrgCode, must be successfully completed. After meeting the training requirements required to administer and interpret the SPDAT Series, practitioners are permitted to implement the SPDAT in their work with clients.

Restrictions on Use

You may not use or copy the SPDAT prior to successfully completing training on its use, provided by OrgCode Consulting, Inc. or a third-party trainer authorized by OrgCode. You may not share the SPDAT with other individuals not trained on its use. You may not train others on the use of the SPDAT, unless specifically authorized by OrgCode Consulting, Inc.

Restrictions on Alteration

You may not modify the SPDAT or create any derivative work of the SPDAT or its accompanying documentation, without the express written consent of OrgCode Consulting, Inc. Derivative works include but are not limited to translations.

Disclaimer

The management and staff of OrgCode Consulting, Inc. (OrgCode) do not control the way in which the Service Prioritization Decision Assistance Tool (SPDAT) will be used, applied or integrated into related client processes by communities, agency management or frontline workers. OrgCode assumes no legal responsibility or liability for the misuse of the SPDAT, decisions that are made or services that are received in conjunction with the assessment tool.

A. Mental Health & Wellness & Cognitive Functioning

PROMPTS	CLIENT SCORE:
• *Have you ever received any help with your mental wellness?* • *Do you feel you are getting all the help you need for your mental health or stress?* • *Has a doctor ever prescribed you pills for nerves, anxiety, depression or anything like that?* • *Have you ever gone to an emergency room or stayed in a hospital because you weren't feeling 100% emotionally?* • *Do you have trouble learning or paying attention?* • *Have you ever had testing done to identify learning disabilities?* • *Do you know if, when pregnant with you, your mother did anything that we now know can have negative effects on the baby?* • *Have you ever hurt your brain or head?* • *Do you have any documents or papers about your mental health or brain functioning?* • *Are there other professionals we could speak with that have knowledge of your mental health?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ Serious and persistent mental illness (2+ hospitalizations in a mental health facility or psychiatric ward in the past 2 years) **and** not in a heightened state of recovery currently ☐ Major barriers to performing tasks and functions of daily living or communicating intent because of a brain injury, learning disability or developmental disability
3	**Any** of the following: ☐ Heightened concerns about state of mental health, but fewer than 2 hospitalizations, and/or without knowledge of presence of a diagnosable mental health condition ☐ Diminished ability to perform tasks and functions of daily living or communicating intent because of a brain injury, learning disability or developmental disability
2	While there may be concern for overall mental health or mild impairments to performing tasks and functions of daily living or communicating intent, **all** of the following are true: ☐ No major concerns about safety or ability to be housed without intensive supports to assist with mental health or cognitive functioning ☐ No major concerns for the health and safety of others because of mental health or cognitive functioning ability ☐ No compelling reason for screening by an expert in mental health or cognitive functioning prior to housing to fully understand capacity
1	☐ In a heightened state of recovery, has a Wellness Recovery Action Plan (WRAP) or similar plan for promoting wellness, understands symptoms and strategies for coping with them, **and** is engaged with mental health supports as necessary.
0	☐ No mental health or cognitive functioning issues disclosed, suspected or observed.

B. Physical Health & Wellness

PROMPTS	CLIENT SCORE:
• *How is your health?* • *Are you getting any help with your health? How often?* • *Do you feel you are getting all the care you need for your health?* • *Any illness like diabetes, HIV, Hep C or anything like that going on?* • *Ever had a doctor tell you that you have problems with blood pressure or heart or lungs or anything like that?* • *When was the last time you saw a doctor? What was that for?* • *Do you have a clinic or doctor that you usually go to?* • *Anything going on right now with your health that you think would prevent you from living a full, healthy, happy life?* • *Are there other professionals we could speak with that have knowledge of your health?* • *Do you have any documents or papers about your health or past stays in hospital because of your health?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ Co-occurring chronic health conditions ☐ Attempting a treatment protocol for a chronic health condition, but the treatment is not improving health ☐ Pallative health condition
3	Presence of a health issue with **any** of the following: ☐ Not connected with professional resources to assist with a real or perceived serious health issue, by choice ☐ Single chronic or serious health concern but does not connect with professional resources because of insufficient community resources (e.g. lack of availability or affordability) ☐ Unable to follow the treatment plan as a direct result of homeless status
2	☐ Presence of a relatively minor physical health issue, which is managed and/or cared for with appropriate professional resources or through informed self-care ☐ Presence of a physical health issue, for which appropriate treatment protocols are followed, but there is still a moderate impact on their daily living
1	Single chronic or serious health condition, but **all** of the following are true: ☐ Able to manage the health issue and live a relatively active and healthy life ☐ Connected to appropriate health supports ☐ Educated and informed on how to manage the health issue, take medication as necessary related to the condition, and consistently follow these requirements.
0	☐ No serious or chronic health condition disclosed, observed, or suspected ☐ If any minor health condition, they are managed appropriately

C. Medication

PROMPTS	CLIENT SCORE:
• *Have you recently been prescribed any medications by a health care professional?* • *Do you take any medications prescribed to you by a doctor?* • *Have you ever sold some or all of your prescription?* • *Have you ever had a doctor prescribe you medication that you didn't have filled at a pharmacy or didn't take?* • *Were any of your medications changed in the last month? If yes: How did that make you feel?* • *Do other people ever steal your medications?* • *Do you ever share your medications with other people?* • *How do you store your medications and make sure you take the right medication at the right time each day?* • *What do you do if you realize you've forgotten to take your medications?* • *Do you have any papers or documents about the medications you take?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ In the past 30 days, started taking a prescription which **is** having any negative impact on day to day living, socialization or mood ☐ Shares or sells prescription, but keeps **less** than is sold or shared ☐ Regularly misuses medication (e.g. frequently forgets; often takes the wrong dosage; uses some or all of medication to get high) ☐ Has had a medication prescribed in the last 90 days that remains unfilled, for any reason
3	**Any** of the following: ☐ In the past 30 days, started taking a prescription which is **not** having any negative impact on day to day living, socialization or mood ☐ Shares or sells prescription, but keeps **more** than is sold or shared ☐ Requires intensive assistance to manage or take medication (e.g., assistance organizing in a pillbox; working with pharmacist to blister-pack; adapting the living environment to be more conducive to taking medications at the right time for the right purpose, like keeping nighttime medications on the bedside table and morning medications by the coffeemaker) ☐ Medications are stored and distributed by a third-party
2	**Any** of the following: ☐ Fails to take medication at the appropriate time or appropriate dosage, 1-2 times per week ☐ Self-manages medications except for requiring reminders or assistance for refills ☐ Successfully self-managing medication for fewer than 30 consecutive days
1	☐ Successfully self-managing medications for more than 30, but less than 180, consecutive days
0	**Any** of the following: ☐ No medication prescribed to them ☐ Successfully self-managing medication for 181+ consecutive days

D. Substance Use

PROMPTS	CLIENT SCORE:
• *When was the last time you had a drink or used drugs?* • *Is there anything we should keep in mind related to drugs or alcohol?* • *[If they disclose use of drugs and/or alcohol] How frequently would you say you use [specific substance] in a week?* • *Ever have a doctor tell you that your health may be at risk because you drink or use drugs?* • *Have you engaged with anyone professionally related to your substance use that we could speak with?* • *Ever get into fights, fall down and bang your head, or pass out when drinking or using other drugs?* • *Have you ever used alcohol or other drugs in a way that may be considered less than safe?* • *Do you ever end up doing things you later regret after you have gotten really hammered?* • *Do you ever drink mouthwash or cooking wine or hand sanitizer or anything like that?*	**NOTES**

Note: Consumption thresholds: 2 drinks per day or 14 total drinks in any one week period for men; 2 drinks per day or 9 total drinks in any one week period for women.

	SCORING
4	☐ In a life-threatening health situation as a direct result of substance use, **or**, In the past 30 days, **any** of the following are true... ☐ Substance use is almost daily (21+ times) **and** often to the point of complete inebriation ☐ Binge drinking, non-beverage alcohol use, or inhalant use 4+ times ☐ Substance use resulting in passing out 2+ times
3	☐ Experiencing serious health impacts as a direct result of substance use, though not (yet) in a life-threatening position as a result, **or**, In the past 30 days, **any** of the following are true... ☐ Drug use reached the point of complete inebriation 12+ times ☐ Alcohol use usually exceeded the consumption thresholds (at least 5+ times), but usually not to the point of complete inebriation ☐ Binge drinking, non-beverage alcohol use, or inhalant use occurred 1-3 times
2	In the past 30 days, **any** of the following are true... ☐ Drug use reached the point of complete inebriation fewer than 12 times ☐ Alcohol use exceeded the consumption thresholds fewer than 5 times
1	☐ In the past 365 days, no alcohol use beyond consumption thresholds, **or**, ☐ If making claims to sobriety, no substance use in the past 30 days
0	☐ In the past 365 days, no substance use

E. Experience of Abuse & Trauma

PROMPTS	CLIENT SCORE:
To avoid re-traumatizing the individual, ask selected approved questions as written. Do not probe for details of the trauma/abuse. This section is entirely self-reported. • *"I don't need you to go into any details, but has there been any point in your life where you experienced emotional, physical, sexual or psychological abuse?"* • *"Are you currently or have you ever received professional assistance to address that abuse?"* • *"Does the experience of abuse or trauma impact your day to day living in any way?"* • *"Does the experience of abuse or trauma impact your ability to hold down a job, maintain housing or engage in meaningful relationships with friends or family?"* • *"Have you ever found yourself feeling or acting in a certain way that you think is caused by a history of abuse or trauma?"* • *"Have you ever become homeless as a direct result of experiencing abuse or trauma?"*	**NOTES**

SCORING	
4	☐ A reported experience of abuse or trauma, believed to be a direct cause of their homelessness
3	☐ The experience of abuse or trauma is **not** believed to be a direct cause of homelessness, but abuse or trauma (experienced before, during, or after homelessness) **is** impacting daily functioning and/or ability to get out of homelessness
2	**Any** of the following: ☐ A reported experience of abuse or trauma, but is not believed to impact daily functioning and/or ability to get out of homelessness ☐ Engaged in therapeutic attempts at recovery, but does not consider self to be recovered
1	☐ A reported experience of abuse or trauma, and considers self to be recovered
0	☐ No reported experience of abuse or trauma

F. Risk of Harm to Self or Others

PROMPTS	CLIENT SCORE:
• *Do you have thoughts about hurting yourself or anyone else? Have you ever acted on these thoughts? When was the last time?* • *What was occurring when you had these feelings or took these actions?* • *Have you ever received professional help – including maybe a stay at hospital – as a result of thinking about or attempting to hurt yourself or others? How long ago was that? Does that happen often?* • *Have you recently left a situation you felt was abusive or unsafe? How long ago was that?* • *Have you been in any fights recently - whether you started it or someone else did? How long ago was that? How often do you get into fights?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ In the past 90 days, left an abusive situation ☐ In the past 30 days, attempted, threatened, or actually harmed self or others ☐ In the past 30 days, involved in a physical altercation (instigator or participant)
3	**Any** of the following: ☐ In the past 180 days, left an abusive situation, but no exposure to abuse in the past 90 days ☐ Most recently attempted, threatened, or actually harmed self or others in the past 180 days, but not in the past 30 days ☐ In the past 365 days, involved in a physical altercation (instigator or participant), but not in the past 30 days
2	**Any** of the following: ☐ In the past 365 days, left an abusive situation, but no exposure to abuse in the past 180 days ☐ Most recently attempted, threatened, or actually harmed self or others in the past 365 days, but not in the past 180 days ☐ 366+ days ago, 4+ involvements in physical alterations
1	☐ 366+ days ago, 1-3 involvements in physical alterations
0	☐ Reports no instance of harming self, being harmed, or harming others

G. Involvement in Higher Risk and/or Exploitive Situations

PROMPTS	CLIENT SCORE:
• *[Observe, don't ask] Any abcesses or track marks from injection substance use?* • *Does anybody force or trick you to do something that you don't want to do?* • *Do you ever do stuff that could be considered dangerous like drinking until you pass out outside, or delivering drugs for someone, having sex without a condom with a casual partner, or anything like that?* • *Do you ever find yourself in situations that may be considered at a high risk for violence?* • *Do you ever sleep outside? How do you dress and prepare for that? Where do you tend to sleep?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ In the past 180 days, engaged in 10+ higher risk and/or exploitive events ☐ In the past 90 days, left an abusive situation
3	**Any** of the following: ☐ In the past 180 days, engaged in 4-9 higher risk and/or exploitive events ☐ In the past 180 days, left an abusive situation, but not in the past 90 days
2	**Any** of the following: ☐ In the past 180 days, engaged in 1-3 higher risk and/or exploitive events ☐ 181+ days ago, left an abusive situation
1	☐ Any involvement in higher risk and/or exploitive situations occurred more than 180 days ago but less than 365 days ago
0	☐ In the past 365 days, no involvement in higher risk and/or exploitive events

H. Interaction with Emergency Services

PROMPTS	CLIENT SCORE:
• *How often do you go to emergency rooms?* • *How many times have you had the police speak to you over the past 180 days?* • *Have you used an ambulance or needed the fire department at any time in the past 180 days?* • *How many times have you called or visited a crisis team or a crisis counselor in the last 180 days?* • *How many times have you been admitted to hospital in the last 180 days? How long did you stay?*	**NOTES**

Note: Emergency service use includes: admittance to emergency room/department; hospitalizations; trips to a hospital in an ambulance; crisis service, distress centers, suicide prevention service, sexual assault crisis service, sex worker crisis service, or similar service; interactions with police for the purpose of law enforcement; interactions with fire service in emergency situations.

SCORING	
4	☐ In the past 180 days, cumulative total of 10+ interactions with emergency services
3	☐ In the past 180 days, cumulative total of 4-9 interactions with emergency services
2	☐ In the past 180 days, cumulative total of 1-3 interactions with emergency services
1	☐ Any interaction with emergency services occurred more than 180 days ago but less than 365 days ago
0	☐ In the past 365 days, no interaction with emergency services

I. Legal

PROMPTS	CLIENT SCORE:
• *Do you have any "legal stuff" going on?* • *Have you had a lawyer assigned to you by a court?* • *Do you have any upcoming court dates? Do you think there's a chance you will do time?* • *Any involvement with family court or child custody matters?* • *Any outstanding fines?* • *Have you paid any fines in the last 12 months for anything?* • *Have you done any community service in the last 12 months?* • *Is anybody expecting you to do community service for anything right now?* • *Did you have any legal stuff in the last year that got dismissed?* • *Is your housing at risk in any way right now because of legal issues?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ Current outstanding legal issue(s), likely to result in fines of $500+ ☐ Current outstanding legal issue(s), likely to result in incarceration of 3+ months (cumulatively), inclusive of any time held on remand
3	**Any** of the following: ☐ Current outstanding legal issue(s), likely to result in fines less than $500 ☐ Current outstanding legal issue(s), likely to result in incarceration of less than 90 days (cumulatively), inclusive of any time held on remand
2	**Any** of the following: ☐ In the past 365 days, relatively minor legal issue has occurred and was resolved through community service or payment of fine(s) ☐ Currently outstanding relatively minor legal issue that is unlikely to result in incarceration (but may result in community service)
1	☐ There are no current legal issues, **and** any legal issues that have historically occurred have been resolved without community service, payment of fine, or incarceration
0	☐ No legal issues within the past 365 days, **and** currently no conditions of release

J. Managing Tenancy

PROMPTS	CLIENT SCORE:
• *Are you currently homeless?* • *[If the person is housed] Do you have an eviction notice?* • *[If the person is housed] Do you think that your housing is at risk?* • *How is your relationship with your neighbors?* • *How do you normally get along with landlords?* • *How have you been doing with taking care of your place?*	**NOTES**

Note: Housing matters include: conflict with landlord and/or neighbors, damages to the unit, payment of rent on time and in full. Payment of rent through a third party is <u>not</u> considered to be a short-coming or deficiency in the ability to pay rent.

SCORING	
4	**Any** of the following: ☐ Currently homeless ☐ In the next 30 days, will be re-housed or return to homelessness ☐ In the past 365 days, was re-housed 6+ times ☐ In the past 90 days, support worker(s) have been cumulatively involved 10+ times with housing matters
3	**Any** of the following: ☐ In the next 60 days, will be re-housed or return to homelessness, but not in next 30 days ☐ In the past 365 days, was re-housed 3-5 times ☐ In the past 90 days, support worker(s) have been cumulatively involved 4-9 times with housing matters
2	**Any** of the following: ☐ In the past 365 days, was re-housed 2 times ☐ In the past 180 days, was re-housed 1+ times, but not in the past 60 days ☐ Continuously housed for at least 90 days but not more than 180 days ☐ In the past 90 days, support worker(s) have been cumulatively involved 1-3 times with housing matters
1	**Any** of the following: ☐ In the past 365 days, was re-housed 1 time ☐ Continuously housed, with no assistance on housing matters, for at least 180 days but not more than 365 days
0	☐ Continuously housed, with no assistance on housing matters, for at least 365 days

K. Personal Administration & Money Management

PROMPTS	CLIENT SCORE:
• *How are you with taking care of money?* • *How are you with paying bills on time and taking care of other financial stuff?* • *Do you have any street debts?* • *Do you have any drug or gambling debts?* • *Is there anybody that thinks you owe them money?* • *Do you budget every single month for every single thing you need? Including cigarettes? Booze? Drugs?* • *Do you try to pay your rent before paying for anything else?* • *Are you behind in any payments like child support or student loans or anything like that?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ Cannot create or follow a budget, regardless of supports provided ☐ Does not comprehend financial obligations ☐ Does not have an income (including formal and informal sources) ☐ Not aware of the full amount spent on substances, if they use substances ☐ Substantial real or perceived debts of $1,000+, past due or requiring monthly payments
3	**Any** of the following: ☐ Requires intensive assistance to create and manage a budget (including any legally mandated guardian/trustee that provides assistance or manages access to money) ☐ Only understands their financial obligations with the assistance of a 3rd party ☐ Not budgeting for substance use, if they are a substance user ☐ Real or perceived debts of $999 or less, past due or requiring monthly payments
2	**Any** of the following: ☐ In the past 365 days, source of income has changed 2+ times ☐ Budgeting to the best of ability (including formal and informal sources), but still short of money every month for essential needs ☐ Voluntarily receives assistance creating and managing a budget or restricts access to their own money (e.g. guardian/trusteeship) ☐ Has been self-managing financial resources and taking care of associated administrative tasks for less than 90 days
1	☐ Has been self-managing financial resources and taking care of associated administrative tasks for at least 90 days, but for less than 180 days
0	☐ Has been self-managing financial resources and taking care of associated administrative tasks for at least 180 days

L. Social Relationships & Networks

PROMPTS	CLIENT SCORE:
• *Tell me about your friends, family or other people in your life.* • *How often do you get together or chat?* • *When you go to doctor's appointments or meet with other professionals like that, what is that like?* • *Are there any people in your life that you feel are just using you?* • *Are there any of your closer friends that you feel are always asking you for money, smokes, drugs, food or anything like that?* • *Have you ever had people crash at your place that you did not want staying there?* • *Have you ever been threatened with an eviction or lost a place because of something that friends or family did in your apartment?* • *Have you ever been concerned about not following your lease agreement because of your friends or family?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ In the past 90 days, left an exploitive, abusive or dependent relationship ☐ Friends, family or other people are placing security of housing at imminent risk, **or** impacting life, wellness, or safety ☐ No friends or family and demonstrates no ability to follow social norms ☐ Currently homeless and would classify most of friends and family as homeless
3	**Any** of the following: ☐ In the past 90-180 days, left an exploitive, abusive or dependent relationship ☐ Friends, family or other people are having some negative consequences on wellness or housing stability ☐ No friends or family but demonstrating ability to follow social norms ☐ Meeting new people with an intention of forming friendships ☐ Reconnecting with previous friends or family members, but experiencing difficulty advancing the relationship ☐ Currently homeless, and would classify some of friends and family as being housed, while others are homeless
2	**Any** of the following: ☐ More than 180 days ago, left an exploitive, abusive or dependent relationship ☐ Developing relationships with new people but not yet fully trusting them ☐ Currently homeless, and would classify friends and family as being housed
1	☐ Has been housed for less than 180 days, **and** is engaged with friends or family, who are having no negative consequences on the individual's housing stability
0	☐ Has been housed for at least 180 days, **and** is engaged with friends or family, who are having no negative consequences on the individual's housing stability

M. Self Care & Daily Living Skills

PROMPTS	CLIENT SCORE:
• *Do you have any worries about taking care of yourself?* • *Do you have any concerns about cooking, cleaning, laundry or anything like that?* • *Do you ever need reminders to do things like shower or clean up?* • *Describe your last apartment.* • *Do you know how to shop for nutritious food on a budget?* • *Do you know how to make low cost meals that can result in leftovers to freeze or save for another day?* • *Do you tend to keep all of your clothes clean?* • *Have you ever had a problem with mice or other bugs like cockroaches as a result of a dirty apartment?* • *When you have had a place where you have made a meal, do you tend to clean up dishes and the like before they get crusty?*	**NOTES**

	SCORING
4	**Any** of the following: ☐ No insight into how to care for themselves, their apartment or their surroundings ☐ Currently homeless and relies upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing) on an almost daily basis ☐ Engaged in hoarding or collecting behavior and is not aware that it is an issue in her/his life
3	**Any** of the following: ☐ Has insight into some areas of how to care for themselves, their apartment or their surroundings, but misses other areas because of lack of insight ☐ In the past 180 days, relied upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing), 14+ days in any 30-day period ☐ Engaged in hoarding or collecting behavior and is aware that it is an issue in her/his life
2	**Any** of the following: ☐ Fully aware and has insight in all that is required to take care of themselves, their apartment and their surroundings, but has not yet mastered the skills or time management to fully execute this on a regular basis ☐ In the past 180 days, relied upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing), fewer than 14 days in every 30-day period
1	☐ In the past 365 days, accessed community resources 4 or fewer times, **and** is fully taking care of all their daily needs
0	☐ For the past 365+ days, fully taking care of all their daily needs independently

N. Meaningful Daily Activity

PROMPTS	CLIENT SCORE:
• *How do you spend your day?* • *How do you spend your free time?* • *Does that make you feel happy/fulfilled?* • *How many days a week would you say you have things to do that make you feel happy/fulfilled?* • *How much time in a week would you say you are totally bored?* • *When you wake up in the morning, do you tend to have an idea of what you plan to do that day?* • *How much time in a week would you say you spend doing stuff to fill up the time rather than doing things that you love?* • *Are there any things that get in the way of you doing the sorts of activities you would like to be doing?*	**NOTES**

SCORING	
4	☐ No planned, legal activities described as providing fulfillment or happiness
3	☐ Discussing, exploring, signing up for and/or preparing for new activities or to re-engage with planned, legal activities that used to provide fulfillment or happiness
2	☐ Attempting new or re-engaging with planned, legal activities that used to provide fulfillment or happiness, but uncertain that activities selected are currently providing fulfillment or happiness, **or** the individual is not fully committed to continuing the activities.
1	☐ Has planned, legal activities described as providing fulfillment or happiness 1-3 days per week
0	☐ Has planned, legal activities described as providing fulfillment or happiness 4+ days per week

O. History of Homelessness & Housing

PROMPTS	CLIENT SCORE:
• *How long have you been homeless?* • *How many times have you been homeless in your life other than this most recent time?* • *Have you spent any time sleeping on a friend's couch or floor? And if so, during those times did you consider that to be your permanent address?* • *Have you ever spent time sleeping in a car or alleyway or garage or barn or bus shelter or anything like that?* • *Have you ever spent time sleeping in an abandoned building?* • *Were you ever in hospital or jail for a period of time when you didn't have a permanent address to go to when you got out?*	**NOTES**

SCORING	
4	☐ Over the past 10 years, cumulative total of 5+ years of homelessness
3	☐ Over the past 10 years, cumulative total of 2+ years but fewer than 5 years of homelessness
2	☐ Over the past 4 years, cumulative total of 30+ days but fewer than 2 years of homelessness
1	☐ Over the past 4 years, cumulative total of 7+ days but fewer than 30 days of homelessness
0	☐ Over the past 4 years, cumulative total of 7 or fewer days of homelessness

Client:	Worker:	Version:	Date:

COMPONENT	SCORE	COMMENTS
MENTAL HEALTH & WELLNESS AND COGNITIVE FUNCTIONING		
PHYSICAL HEALTH & WELLNESS		
MEDICATION		
SUBSTANCE USE		
EXPERIENCE OF ABUSE AND/ OR TRAUMA		
RISK OF HARM TO SELF OR OTHERS		
INVOLVEMENT IN HIGHER RISK AND/OR EXPLOITIVE SITUATIONS		
INTERACTION WITH EMERGENCY SERVICES		

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Client:	Worker:	Version:	Date:

COMPONENT	SCORE	COMMENTS
LEGAL INVOLVEMENT		
MANAGING TENANCY		
PERSONAL ADMINISTRATION & MONEY MANAGEMENT		
SOCIAL RELATIONSHIPS & NETWORKS		
SELF-CARE & DAILY LIVING SKILLS		
MEANINGFUL DAILY ACTIVITIES		
HISTORY OF HOUSING & HOMELESSNESS		
TOTAL		**Score: Recommendation:** 0-19: No housing intervention 20-34: Rapid Re-Housing 35-60: Permanent Supportive Housing/Housing First

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Appendix A: About the SPDAT

OrgCode Consulting, Inc. is pleased to announce the release of Version 4 of the Service Prioritization Decision Assistance Tool (SPDAT). Since its release in 2010, the SPDAT has been used with over 10,000 unique individuals in over 100 communities across North America and in select locations around the world.

Originally designed as a tool to help prioritize housing services for homeless individuals based upon their acuity, the SPDAT has been successfully adapted to other fields of practice, including: discharge planning from hospitals, work with youth, survivors of domestic violence, health research, planning supports for consumer survivors of psychiatric care systems, and in work supporting people with fetal alcohol spectrum disorders. We are encouraged that so many service providers and communities are expanding the use of this tool, and OrgCode will continue to support the innovative use of the SPDAT to meet local needs.

SPDAT Design

The SPDAT is designed to:

- Help prioritize which clients should receive what type of housing assistance intervention, and assist in determining the intensity of case management services
- Prioritize the sequence of clients receiving those services
- Help prioritize the time and resources of Frontline Workers
- Allow Team Leaders and program supervisors to better match client needs to the strengths of specific Frontline Workers on their team
- Assist Team Leaders and program supervisors to support Frontline Workers and establish service priorities across their team
- Provide assistance with case planning and encourage reflection on the prioritization of different elements within a case plan
- Track the depth of need and service responses to clients over time

The SPDAT is NOT designed to:

- Provide a diagnosis
- Assess current risk or be a predictive index for future risk
- Take the place of other valid and reliable instruments used in clinical research and care

The SPDAT is only used with those clients who meet program eligibility criteria. For example, if there is an eligibility criterion that requires prospective clients to be homeless at time of intake to be eligible for Housing First, then the pre-condition must be met before pursuing the application of the SPDAT. For that reason, we have also created the VI-SPDAT as an initial screening tool.

The SPDAT is not intended to replace clinical expertise or clinical assessment tools. The tool complements existing clinical approaches by incorporating a wide array of components that provide both a global and detailed picture of a client's acuity. Certain components of the SPDAT relate to clinical concerns, and it is expected that intake professionals and clinicians will work together to ensure the accurate assessment of these issues. In fact, many organizations and communities have found the SPDAT to be a useful method for bridging the gap between housing, social services and clinical services.

Version 4

The SPDAT has been influenced by the experience of practitioners in its use, persons with lived experience that have had the SPDAT implemented with them, as well as a number of other excellent tools such as (but not limited to) the Outcome Star, Health of the Nation Outcome Scale, Denver Acuity Scale, Camberwell Assessment of Needs, Vulnerability Index, and Transition Aged Youth Triage Tool.

In preparing SPDAT v4, we have adopted a comprehensive and collaborative approach to changing and improving the SPDAT. Communities that have used the tool for three months or more have provided us with their feedback. OrgCode staff have observed the tool in operation to better understand its implementation in the field. An independent committee composed of service practitioners and academics review enhancements to the SPDAT. Furthermore, we continue to test the validity of SPDAT results through the use of control groups. Overall, we consistently see that groups assessed with the SPDAT have better long-term housing and life stability outcomes than those assessed with other tools, or no tools at all.

OrgCode intends to continue working with communities and persons with lived experience to make future versions of the SPDAT even better. We hope all those communities and agencies that choose to use this tool will remain committed to collaborating with us to make those improvements over time.

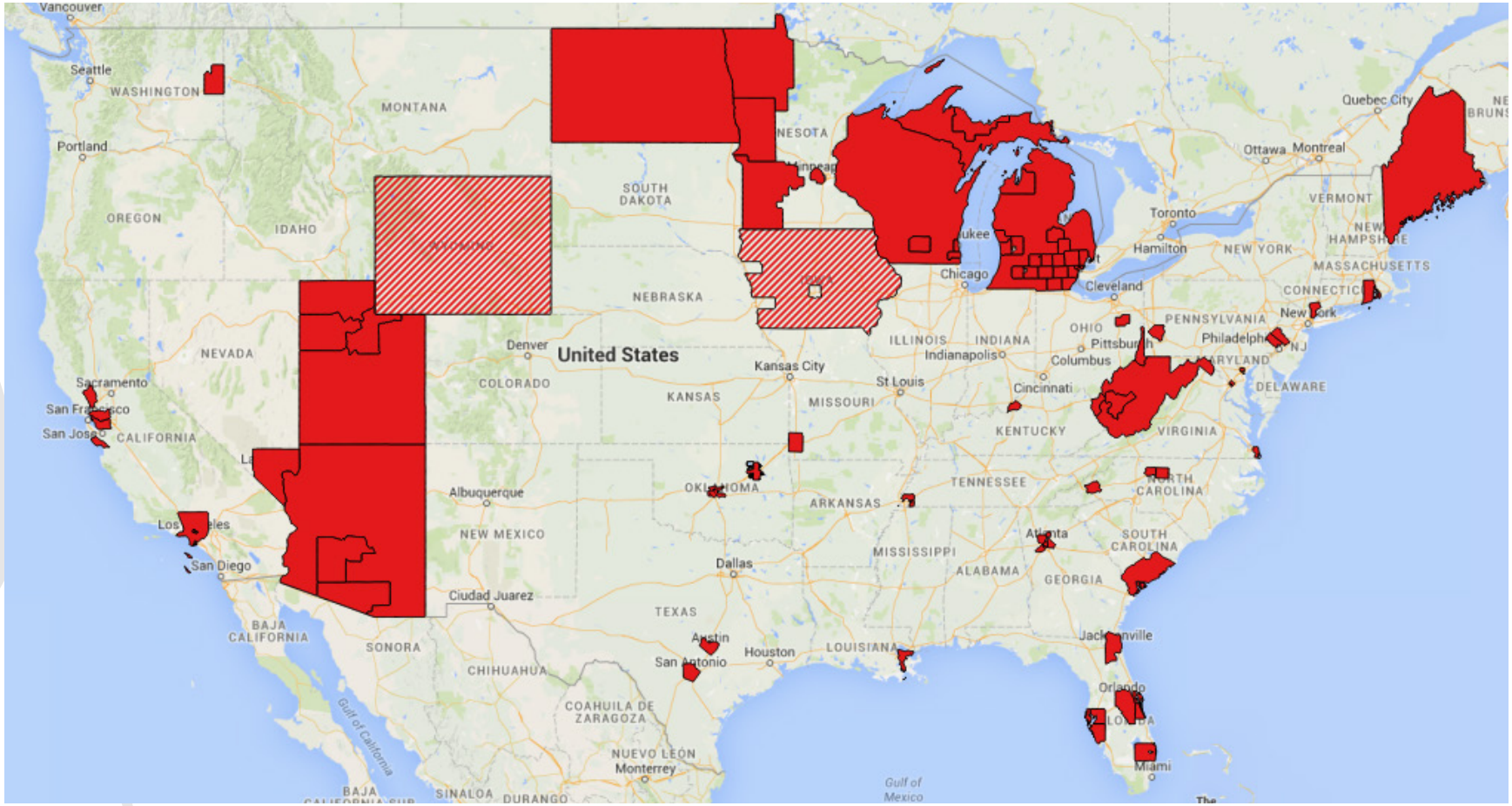
Version 4 builds upon the success of Version 3 of the SPDAT with some refinements. Starting in August 2014, a survey was launched of existing SPDAT users to get their input on what should be amended, improved, or maintained in the tool. Analysis was completed across all of these responses. Further research was conducted. Questions were tested and refined over several months, again including the direct voice of persons with lived experience and frontline practitioners. Input was also gathered from senior government officials that create policy and programs to help ensure alignment with guidelines and funding requirements.

The major differences from Version 3 to Version 4 include:

- The structure of the tools is the same: four domains (five for families) with components aligned to specific domains. The names of the domains and the components remain unchanged.
- The scoring of the tools is the same: 60 points for singles, and 80 points for families.
- The scoring tables used to run from 0 through to 4. They are now reversed with each table starting at 4 and working their way down to 0. This increases the speed of assessment.
- The order of the tools has changed, grouped together by domain.
- Language has been simplified.
- Days are used rather than months to provide greater clarification and alignment to how most databases capture periods of time in service.
- Greater specificity has been provided in some components such as amount of debts.

Appendix B: Where the SPDAT is being used (as of May 2015)

United States of America



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Arizona
- Statewide

California
- Oakland/Alameda County CoC
- Richmond/Contra Costa County CoC
- Watsonville/Santa Cruz City & County CoC
- Napa City & County CoC
- Los Angeles City & County CoC
- Pasadena CoC
- Glendale CoC

District of Columbia
- District of Columbia CoC

Florida
- Sarasota/Bradenton/Manatee, Sarasota Counties CoC
- Tampa/Hillsborough County CoC
- St. Petersburg/Clearwater/Largo/Pinellas County CoC
- Orlando/Orange, Osceola, Seminole Counties CoC
- Jacksonville-Duval, Clay Counties CoC
- Palm Bay/Melbourne/Brevard County CoC
- West Palm Beach/Palm Beach County CoC

Georgia
- Atlanta County CoC
- Fulton County CoC
- Marietta/Cobb County CoC
- DeKalb County CoC

Iowa
- Parts of Iowa Balance of State CoC

Kentucky
- Louisville/Jefferson County CoC

Louisiana
- New Orleans/Jefferson Parish CoC

Maryland
- Baltimore City CoC

Maine
- Statewide

Michigan
- Statewide

Minnesota
- Minneapolis/Hennepin County CoC
- Northwest Minnesota CoC
- Moorhead/West Central Minnesota CoC
- Southwest Minnesota CoC

Missouri
- Joplin/Jasper, Newton Counties CoC

North Carolina
- Winston Salem/Forsyth County CoC
- Asheville/Buncombe County CoC
- Greensboro/High Point CoC

North Dakota
- Statewide

Nevada
- Las Vegas/Clark County CoC

New York
- Yonkers/Mount Vernon/New Rochelle/Westchester County CoC

Ohio
- Canton/Massillon/Alliance/Stark County CoC
- Toledo/Lucas County CoC

Oklahoma
- Tulsa City & County/Broken Arrow CoC
- Oklahoma City CoC

Pennsylvania
- Lower Marion/Norristown/Abington/Montgomery County CoC
- Bristol/Bensalem/Bucks County CoC
- Pittsburgh/McKeesport/Penn Hills/Allegheny County CoC

Rhode Island
- Statewide

South Carolina
- Charleston/Low Country CoC

Tennessee
- Memphis/Shelby County CoC

Texas
- San Antonio/Bexar County CoC
- Austin/Travis County CoC

Utah
- Salt Lake City & County CoC
- Utah Balance of State CoC
- Provo/Mountainland CoC

Virginia
- Virginia Beach CoC
- Arlington County CoC

Washington
- Spokane City & County CoC

Wisconsin
- Statewide

West Virginia
- Statewide

Wyoming
- Wyoming is in the process of implementing statewide

Canada

Alberta
- Province-wide

Manitoba
- City of Winnipeg

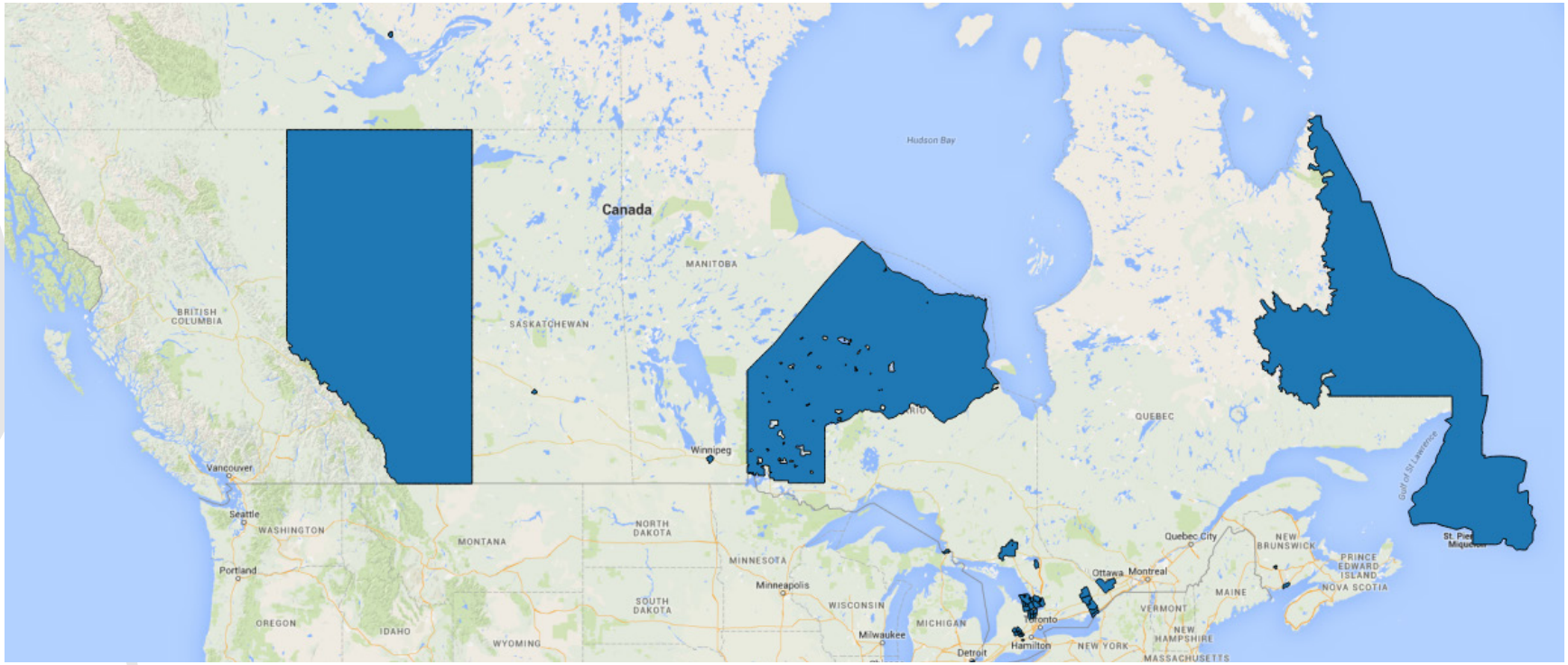
New Brunswick
- City of Fredericton
- City of Saint John

Newfoundland and Labrador
- Province-wide

Northwest Territories
- City of Yellowknife

Ontario
- City of Barrie/Simcoe County
- City of Brantford/Brant County
- City of Greater Sudbury
- City of Kingston/Frontenac County
- City of Ottawa
- City of Windsor
- District of Kenora
- District of Parry Sound
- District of Sault Ste Marie
- Regional Municipality of Waterloo
- Regional Municipality of York

Saskatchewan
- Saskatoon



Australia

Queensland
- Brisbane

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Family Service Prioritization Decision Assistance Tool

(F-SPDAT)

Assessment Tool for Families

VERSION 2.01

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

Welcome to the SPDAT Line of Products

The Service Prioritization Decision Assistance Tool (SPDAT) has been around in various incarnations for over a decade, before being released to the public in 2010. Since its initial release, the use of the SPDAT has been expanding exponentially and is now used in over one thousand communities across the United States, Canada, and Australia.

More communities using the tool means there is an unprecedented demand for versions of the SPDAT, customized for specific client groups or service delivery contexts. With the release of SPDAT V4, there have been more current versions of SPDAT products than ever before.

VI-SPDAT Series

The **Vulnerability Index – Service Prioritization Decision Assistance Tool** (VI-SPDAT) was developed as a pre-screening tool for communities that are very busy and may not have the resources to conduct a full SPDAT assessment for every client. It was made in collaboration with Community Solutions, creators of the Vulnerability Index, as a brief survey that can be conducted to quickly determine whether a client has high, moderate, or low acuity. The use of this survey can help prioritize which clients should be given a full SPDAT assessment first. Because it is a self-reported survey, no special training is required to use the VI-SPDAT.

Current versions available:

- VI-SPDAT V 2.0 for Individuals
- VI-SPDAT V 2.0 for Families
- VI-SPDAT V 1.0 for Youth

All versions are available online at

www.orgcode.com/products/vi-spdat/

SPDAT Series

The **Service Prioritization Decision Assistance Tool** (SPDAT) was developed as an assessment tool for frontline workers at agencies that work with homeless clients to prioritize which of those clients should receive assistance first. It is an in-depth assessment that relies on the assessor's ability to interpret responses and corroborate those with evidence. As a result, this tool may only be used by those who have received proper, up-to-date training provided by OrgCode Consulting, Inc. or an OrgCode certified trainer.

Current versions available:

- SPDAT V 4.0 for Individuals
- SPDAT V 2.0 for Families
- SPDAT V 1.0 for Youth

Information about all versions is available online at

www.orgcode.com/products/spdat/

SPDAT Training Series

To use the SPDAT, training by OrgCode or an OrgCode certified trainer is required. We provide training on a wide variety of topics over a variety of mediums.

The full-day in-person SPDAT Level 1 training provides you the opportunity to bring together as many people as you want to be trained for one low fee. The webinar training allows for a maximum of 15 different computers to be logged into the training at one time. We also offer online courses for individuals that you can do at your own speed.

The training gives you the manual, case studies, application to current practice, a review of each component of the tool, conversation guidance with prospective clients – and more!

Current SPDAT training available:

- Level 0 SPDAT Training: VI-SPDAT for Frontline Workers
- Level 1 SPDAT Training: SPDAT for Frontline Workers
- Level 2 SPDAT Training: SPDAT for Supervisors
- Level 3 SPDAT Training: SPDAT for Trainers

Other related training available:

- Excellence in Housing-Based Case Management
- Coordinated Access & Common Assessment
- Motivational Interviewing
- Objective-Based Interactions

More information about SPDAT training, including pricing, is available online at

http://www.orgcode.com/product-category/training/spdat/

Terms and Conditions Governing the Use of the SPDAT

SPDAT products have been developed by OrgCode Consulting, Inc. with extensive feedback from key community partners including people with lived experience. The tools are provided free of charge to communities to improve the client centered services dedicated to increasing housing stability and wellness. Training is indeed required for the administration and interpretation of these assessment tools. Use of the SPDAT products without authorized training is strictly prohibited.

By using this tool, you accept and agree to be bound by the terms of this expectation.

No sharing, reproduction, use or duplication of the information herein is permitted without the express written consent of OrgCode Consulting, Inc.

Ownership

The Service Prioritization Decision Assistance Tool ("SPDAT") and accompanying documentation is owned by OrgCode Consulting, Inc.

Training

Although the SPDAT Series is provided free of charge to communities, training by OrgCode Consulting, Inc. or a third party trainer, authorized by OrgCode, must be successfully completed. After meeting the training requirements required to administer and interpret the SPDAT Series, practitioners are permitted to implement the SPDAT in their work with clients.

Restrictions on Use

You may not use or copy the SPDAT prior to successfully completing training on its use, provided by OrgCode Consulting, Inc. or a third-party trainer authorized by OrgCode. You may not share the SPDAT with other individuals not trained on its use. You may not train others on the use of the SPDAT, unless specifically authorized by OrgCode Consulting, Inc.

Restrictions on Alteration

You may not modify the SPDAT or create any derivative work of the SPDAT or its accompanying documentation, without the express written consent of OrgCode Consulting, Inc. Derivative works include but are not limited to translations.

Disclaimer

The management and staff of OrgCode Consulting, Inc. (OrgCode) do not control the way in which the Service Prioritization Decision Assistance Tool (SPDAT) will be used, applied or integrated into related client processes by communities, agency management or frontline workers. OrgCode assumes no legal responsibility or liability for the misuse of the SPDAT, decisions that are made or services that are received in conjunction with the assessment tool.

A. Mental Health & Wellness & Cognitive Functioning

PROMPTS	CLIENT SCORE:
• *Has anyone in your family ever received any help with their mental wellness?* • *Do you feel that every member in your family is getting all the help they need for their mental health or stress?* • *Has a doctor ever prescribed anyone in your family pills for nerves, anxiety, depression or anything like that?* • *Has anyone in your family ever gone to an emergency room or stayed in a hospital because they weren't feeling 100% emotionally?* • *Does anyone in your family have trouble learning or paying attention, or been tested for learning disabilities?* • *Do you know if, when pregnant with you, your mother did anything that we now know can have negative effects on the baby? What about when you were pregnant?* • *Has anyone in your family ever hurt their brain or head?* • *Do you have any documents or papers about your family's mental health or brain functioning?* • *Are there other professionals we could speak with that have knowledge of your family's mental health?*	**NOTES**

	SCORING
4	**Any** of the following among any family member: ☐ Serious and persistent mental illness (2+ hospitalizations in a mental health facility or psychiatric ward in the past 2 years) **and** not in a heightened state of recovery currently ☐ Major barriers to performing tasks and functions of daily living or communicating intent because of a brain injury, learning disability or developmental disability
3	**Any** of the following among any family member: ☐ Heightened concerns about state of mental health, but fewer than 2 hospitalizations, and/or without knowledge of presence of a diagnosable mental health condition ☐ Diminished ability to perform tasks and functions of daily living or communicating intent because of a brain injury, learning disability or developmental disability
2	While there may be concern for overall mental health or mild impairments to performing tasks and functions of daily living or communicating intent, **all** of the following are true: ☐ No major concerns about the family's safety or ability to be housed without intensive supports to assist with mental health or cognitive functioning ☐ No major concerns for the health and safety of others because of mental health or cognitive functioning ability ☐ No compelling reason for any member of the family to be screened by an expert in mental health or cognitive functioning prior to housing to fully understand capacity
1	☐ All members of the family are in a heightened state of recovery, have a Wellness Recovery Action Plan (WRAP) or similar plan for promoting wellness, understands symptoms and strategies for coping with them, **and** are engaged with mental health supports as necessary.
0	☐ No mental health or cognitive functioning issues disclosed, suspected or observed.

B. Physical Health & Wellness

PROMPTS	CLIENT SCORE:
• *How is your family's health?* • *Are you getting any help with your health? How often?* • *Do you feel you are getting all the care you need for your family's health?* • *Any illnesses like diabetes, HIV, Hep C or anything like that going on in any member of your family?* • *Ever had a doctor tell anyone in your family that they have problems with blood pressure or heart or lungs or anything like that?* • *When was the last time anyone in your family saw a doctor? What was that for?* • *Do you have a clinic or doctor that you usually go to?* • *Anything going on right now with your family's health that you think would prevent them from living a full, healthy, happy life?* • *Are there other professionals we could speak with that have knowledge of your family's health?* • *Do you have any documents or papers about your family's health or past stays in hospital because of your health?*	**NOTES**

SCORING	
4	**Any** of the following for any member of the family: ☐ Co-occurring chronic health conditions ☐ Attempting a treatment protocol for a chronic health condition, but the treatment is not improving health ☐ Pallative health condition
3	Presence of a health issue among any family member with **any** of the following: ☐ Not connected with professional resources to assist with a real or perceived serious health issue, by choice ☐ Single chronic or serious health concern but does not connect with professional resources because of insufficient community resources (e.g. lack of availability or affordability) ☐ Unable to follow the treatment plan as a direct result of homeless status
2	☐ Presence of a relatively minor physical health issue, which is managed and/or cared for with appropriate professional resources or through informed self-care ☐ Presence of a physical health issue, for which appropriate treatment protocols are followed, but there is still a moderate impact on their daily living
1	Single chronic or serious health condition in a family member, but **all** of the following are true: ☐ Able to manage the health issue and live a relatively active and healthy life ☐ Connected to appropriate health supports ☐ Educated and informed on how to manage the health issue, take medication as necessary related to the condition, and consistently follow these requirements.
0	☐ No serious or chronic health condition ☐ If any minor health condition, they are managed appropriately

C. Medication

PROMPTS	CLIENT SCORE:
• *Has anyone in your family recently been prescribed any medications by a health care professional?* • *Does anyone in your family take any medication, prescribed to them by a doctor?* • *Has anyone in your family ever had a doctor prescribe them a medication that wasn't filled or they didn't take?* • *Were any of your family's medications changed in the last month? Whose? How did that make them feel?* • *Do other people ever steal your family's medications?* • *Does anyone in your family ever sell or share their medications with other people it wasn't prescribed to?* • *How does your family store their medication and make sure they take the right medication at the right time each day?* • *What do you do if you realize someone has forgotten to take their medications?* • *Do you have any papers or documents about the medications your family takes?*	**NOTES**

SCORING	
4	**Any** of the following for any family member: ☐ In the past 30 days, started taking a prescription which **is** having any negative impact on day to day living, socialization or mood ☐ Shares or sells prescription, but keeps **less** than is sold or shared ☐ Regularly misuses medication (e.g. frequently forgets; often takes the wrong dosage; uses some or all of medication to get high) ☐ Has had a medication prescribed in the last 90 days that remains unfilled, for any reason.
3	**Any** of the following for any family member: ☐ In the past 30 days, started taking a prescription which is **not** having any negative impact on day to day living, socialization or mood ☐ Shares or sells prescription, but keeps **more** than is sold or shared ☐ Requires intensive assistance to manage or take medication (e.g., assistance organizing in a pillbox; working with pharmacist to blister-pack; adapting the living environment to be more conducive to taking medications at the right time for the right purpose, like keeping nighttime medications on the bedside table and morning medications by the coffeemaker) ☐ Medications are stored and distributed by a third-party
2	**Any** of the following for any family member: ☐ Fails to take medication at the appropriate time or appropriate dosage, 1-2 times per week ☐ Self-manages medications except for requiring reminders or assistance for refills ☐ Successfully self-managing medication for fewer than 30 consecutive days
1	☐ Successfully self-managing medications for more than 30, but less than 180, consecutive days
0	**Any** of the following is true for **every** family member: ☐ No medication prescribed to them ☐ Successfully self-managing medication for 181+ consecutive days

D. Substance Use

PROMPTS	CLIENT SCORE:
• *When was the last time you had a drink or used drugs? What about the other members of your family?* • *Anything we should keep in mind related to drugs/alcohol?* • *How often would you say you use [substance] in a week?* • *Ever have a doctor tell you that your health may be at risk because you drink or use drugs?* • *Have you engaged with anyone professionally related to your substance use that we could speak with?* • *Ever get into fights, fall down and bang your head, do things you regret later, or pass out when drinking or using other drugs?* • *Have you ever used alcohol or other drugs in a way that may be considered less than safe?* • *Do you ever drink mouthwash or cooking wine or hand sanitizer or anything like that?*	**NOTES**

Note: Consumption thresholds: 2 drinks per day or 14 total drinks in any one week period for men; 2 drinks per day or 9 total drinks in any one week period for women.

SCORING	
4	☐ An adult is in a life-threatening health situation as a direct result of substance use, **or**, ☐ Any family member is under the legal age but over 15 and would score a 3+, **or**, ☐ Any family member is under 15 and would score a 2+, **or** who first used drugs prior to age 12, **or**, In the past 30 days, **any** of the following are true for any adult in the family... ☐ Substance use is almost daily (21+ times) **and** often to the point of complete inebriation ☐ Binge drinking, non-beverage alcohol use, or inhalant use 4+ times ☐ Substance use resulting in passing out 2+ times
3	☐ An adult is experiencing serious health impacts as a direct result of substance use, though not (yet) in a life-threatening position as a result, **or**, ☐ Any family member is under the legal age but over 15 and would score a 2, **or**, ☐ Any family member is under 15 and would score a 1, **or** who first used drugs at age 13-15, **or**, In the past 30 days, **any** of the following are true for any adult in the family... ☐ Drug use reached the point of complete inebriation 12+ times ☐ Alcohol use usually exceeded the consumption thresholds (at least 5+ times), but usually not to the point of complete inebriation ☐ Binge drinking, non-beverage alcohol use, or inhalant use occurred 1-3 times
2	☐ Any family member is under the legal age but over 15 and would otherwise score 1, **or**, In the past 30 days, **any** of the following are true for any adult in the family... ☐ Drug use reached the point of complete inebriation fewer than 12 times ☐ Alcohol use exceeded the consumption thresholds fewer than 5 times
1	☐ In the past 365 days, no alcohol use beyond consumption thresholds, **or**, ☐ If making claims to sobriety, no substance use in the past 30 days
0	☐ In the past 365 days, no substance use

E. Experience of Abuse & Trauma of Parents

PROMPTS	CLIENT SCORE:
To avoid re-traumatizing the individual, ask selected approved questions as written. Do not probe for details of the trauma/abuse. This section is entirely self-reported. ***Because this section is self-reported, if there are more than one parent present, they should each be asked individually.*** • *"I don't need you to go into any details, but has there been any point in your life where you experienced emotional, physical, sexual or psychological abuse?"* • *"Are you currently or have you ever received professional assistance to address that abuse?"* • *"Does the experience of abuse or trauma impact your day to day living in any way?"* • *"Does the experience of abuse or trauma impact your ability to hold down a job, maintain housing or engage in meaningful relationships with friends or family?"* • *"Have you ever found yourself feeling or acting in a certain way that you think is caused by a history of abuse or trauma?"* • *"Have you ever become homeless as a direct result of experiencing abuse or trauma?"*	**NOTES**

SCORING	
4	☐ A reported experience of abuse or trauma, believed to be a direct cause of their homelessness
3	☐ The experience of abuse or trauma is **not** believed to be a direct cause of homelessness, but abuse or trauma (experienced before, during, or after homelessness) **is** impacting daily functioning and/or ability to get out of homelessness
2	**Any** of the following: ☐ A reported experience of abuse or trauma, but is not believed to impact daily functioning and/or ability to get out of homelessness ☐ Engaged in therapeutic attempts at recovery, but does not consider self to be recovered
1	☐ A reported experience of abuse or trauma, and considers self to be recovered
0	☐ No reported experience of abuse or trauma

F. Risk of Harm to Self or Others

PROMPTS	CLIENT SCORE:
• *Does anyone in your family have thoughts about hurting themselves or anyone else? Have they ever acted on these thoughts? When was the last time? What was occurring when that happened?* • *Has anyone in your family ever received professional help – including maybe a stay at hospital – as a result of thinking about or attempting to hurt themself or others? How long ago was that? Does that happen often?* • *Has anyone in your family recently left a situation you felt was abusive or unsafe? How long ago was that?* • *Has anyone in your family been in any fights recently – whether they started it or someone else did? How long ago was that? How often do they get into fights?*	**NOTES**

SCORING	
4	**Any** of the following for any family member: ☐ In the past 90 days, left an abusive situation ☐ In the past 30 days, attempted, threatened, or actually harmed self or others ☐ In the past 30 days, involved in a physical altercation (instigator or participant)
3	**Any** of the following for any family member: ☐ In the past 180 days, left an abusive situation, but no exposure to abuse in the past 90 days ☐ Most recently attempted, threatened, or actually harmed self or others in the past 180 days, but not in the past 30 days ☐ In the past 365 days, involved in a physical altercation (instigator or participant), but not in the past 30 days
2	**Any** of the following for any family member: ☐ In the past 365 days, left an abusive situation, but no exposure to abuse in the past 180 days ☐ Most recently attempted, threatened, or actually harmed self or others in the past 365 days, but not in the past 180 days ☐ 366+ days ago, 4+ involvements in physical alterations
1	☐ 366+ days ago, a family member had 1-3 involvements in physical alterations
0	☐ Whole family reports no instance of harming self, being harmed, or harming others

G. Involvement in Higher Risk and/or Exploitive Situations

PROMPTS	CLIENT SCORE:
• *[Observe, don't ask] Any abscesses or track marks from injection substance use?* • *Does anybody force or trick people in your family to do things that they don't want to do?* • *Do you or anyone in your family ever do stuff that could be considered dangerous like drinking until they pass out outside, or delivering drugs for someone, having sex without a condom with a casual partner, or anything like that?* • *Does anyone in your family ever find themselves in situations that may be considered at a high risk for violence?* • *Does your family ever sleep outside? How do you dress and prepare for that? Where do you tend to sleep?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ In the past 180 days, family engaged in a total of 10+ higher risk and/or exploitive events ☐ In the past 90 days, any member of the family left an abusive situation
3	**Any** of the following: ☐ In the past 180 days, family engaged in a total of 4-9 higher risk and/or exploitive events ☐ In the past 180 days, any member of the family left an abusive situation, but not in the past 90 days
2	**Any** of the following: ☐ In the past 180 days, family engaged in a total of 1-3 higher risk and/or exploitive events ☐ 181+ days ago, any member of the family left an abusive situation
1	☐ Any involvement in higher risk and/or exploitive situations by any member of the family occurred more than 180 days ago but less than 365 days ago
0	☐ In the past 365 days, no involvement by any family member in higher risk and/or exploitive events

H. Interaction with Emergency Services

PROMPTS	CLIENT SCORE:
• *How often does your family go to emergency rooms?* • *How many times have you had the police speak to members of your family over the past 180 days?* • *Has anyone in your family used an ambulance or needed the fire department at any time in the past 180 days?* • *How many times have members of your family called or visited a crisis team or a crisis counselor in the last 180 days?* • *How many times have you or anyone in your family been admitted to hospital in the last 180 days? How long did they stay?*	**NOTES**

Note: Emergency service use includes: admittance to emergency room/department; hospitalizations; trips to a hospital in an ambulance; crisis service, distress centers, suicide prevention service, sexual assault crisis service, sex worker crisis service, or similar service; interactions with police for the purpose of law enforcement; interactions with fire service in emergency situations.

SCORING	
4	☐ In the past 180 days, cumulative family total of 10+ interactions with emergency services
3	☐ In the past 180 days, cumulative family total of 4-9 interactions with emergency services
2	☐ In the past 180 days, cumulative family total of 1-3 interactions with emergency services
1	☐ Any interaction with emergency services by family members occurred more than 180 days ago but less than 365 days ago
0	☐ In the past 365 days, no interaction with emergency services

I. Legal

PROMPTS	CLIENT SCORE:
• *Does your family have any "legal stuff" going on?* • *Has anyone in your family had a lawyer assigned to them by a court?* • *Does anyone in your family have any upcoming court dates? Do you think there's a chance someone in your family will do time?* • *Any outstanding fines?* • *Has anyone in your family paid any fines in the last 12 months for anything?* • *Has anyone in your family done any community service in the last 12 months?* • *Is anybody expecting someone in your family to do community service for anything right now?* • *Did your family have any legal stuff in the last year that got dismissed?* • *Is your family's housing at risk in any way right now because of legal issues?*	**NOTES**

SCORING	
4	**Any** of the following among any family member: ☐ Current outstanding legal issue(s), likely to result in fines of $500+ ☐ Current outstanding legal issue(s), likely to result in incarceration of 3+ months (cumulatively), inclusive of any time held on remand
3	**Any** of the following among any family member: ☐ Current outstanding legal issue(s), likely to result in fines less than $500 ☐ Current outstanding legal issue(s), likely to result in incarceration of less than 90 days (cumulatively), inclusive of any time held on remand
2	**Any** of the following among any family member: ☐ In the past 365 days, relatively minor legal issue has occurred and was resolved through community service or payment of fine(s) ☐ Currently outstanding relatively minor legal issue that is unlikely to result in incarceration (but may result in community service)
1	☐ There are no current legal issues among family members, **and** any legal issues that have historically occurred have been resolved without community service, payment of fine, or incarceration
0	☐ No family member has had any legal issues within the past 365 days, **and** currently no conditions of release

J. Managing Tenancy

PROMPTS	CLIENT SCORE:
• *Is your family currently homeless?* • *[If the family is housed] Does your family have an eviction notice?* • *[If the family is housed] Do you think that your family's housing is at risk?* • *How is your family's relationship with your neighbors?* • *How does your family normally get along with landlords?* • *How has your family been doing with taking care of your place?*	**NOTES**

Note: Housing matters include: conflict with landlord and/or neighbors, damages to the unit, payment of rent on time and in full. Payment of rent through a third party is <u>not</u> considered to be a short-coming or deficiency in the ability to pay rent.

SCORING	
4	**Any** of the following: ☐ Currently homeless ☐ In the next 30 days, will be re-housed or return to homelessness ☐ In the past 365 days, was re-housed 6+ times ☐ In the past 90 days, support worker(s) have been cumulatively involved 10+ times with housing matters
3	**Any** of the following: ☐ In the next 60 days, will be re-housed or return to homelessness, but not in next 30 days ☐ In the past 365 days, was re-housed 3-5 times ☐ In the past 90 days, support worker(s) have been cumulatively involved 4-9 times with housing matters
2	**Any** of the following: ☐ In the past 365 days, was re-housed 2 times ☐ In the past 180 days, was re-housed 1+ times, but not in the past 60 days ☐ Continuously housed for at least 90 days but not more than 180 days ☐ In the past 90 days, support worker(s) have been cumulatively involved 1-3 times with housing matters
1	**Any** of the following: ☐ In the past 365 days, was re-housed 1 time ☐ Continuously housed, with no assistance on housing matters, for at least 180 days but not more than 365 days
0	☐ Continuously housed, with no assistance on housing matters, for at least 365 days

K. Personal Administration & Money Management

PROMPTS	CLIENT SCORE:
• *How are you and your family with taking care of money?* • *How are you and your family with paying bills on time and taking care of other financial stuff?* • *Does anyone in your family have any street debts or drug or gambling debts?* • *Is there anybody that thinks anyone in your family owes them money?* • *Do you budget every single month for every single thing your family needs? Including cigarettes? Booze? Drugs?* • *Does your family try to pay your rent before paying for anything else?* • *Is anyone in your family behind in any payments like child support or student loans or anything like that?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ No family income (including formal and informal sources) ☐ Substantial real or perceived debts of $1,000+, past due or requiring monthly payments **Or**, for the person who normally handles the household's finances, **any** of the following: ☐ Cannot create or follow a budget, regardless of supports provided ☐ Does not comprehend financial obligations ☐ Not aware of the full amount spent on substances, if the household includes a substance user
3	☐ Real or perceived debts of $999 or less, past due or requiring monthly payments, **or** For the person who normally handles the household's finances, **any** of the following: ☐ Requires intensive assistance to create and manage a budget (including any legally mandated guardian/trustee that provides assistance or manages access to money) ☐ Only understands their financial obligations with the assistance of a 3rd party ☐ Not budgeting for substance use, if the household includes a substance user
2	☐ In the past 365 days, source of family income has changed 2+ times, **or** For the person who normally handles the household's finances, **any** of the following: ☐ Budgeting to the best of ability (including formal and informal sources), but still short of money every month for essential needs ☐ Voluntarily receives assistance creating and managing a budget or restricts access to their own money (e.g. guardian/trusteeship) ☐ Self-managing financial resources and taking care of associated administrative tasks for less than 90 days
1	☐ The person who normally handles the household's finances has been self-managing financial resources and taking care of associated administrative tasks for at least 90 days, but for less than 180 days
0	☐ The person who normally handles the household's finances has been self-managing financial resources and taking care of associated administrative tasks for at least 180 days

L. Social Relationships & Networks

PROMPTS	CLIENT SCORE:
• *Tell me about your family's friends, extended family or other people in your life.* • *How often do you get together or chat with family friends?* • *When your family goes to doctor's appointments or meet with other professionals like that, what is that like?* • *Are there any people in your life that you feel are just using you, or someone else in your family?* • *Are there any of your family's closer friends that you feel are always asking you for money, smokes, drugs, food or anything like that?* • *Have you ever had people crash at your place that you did not want staying there?* • *Have you ever been threatened with an eviction or lost a place because of something that friends or extended family did in your apartment?* • *Have you ever been concerned about not following your lease agreement because of friends or extended family?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ Currently homeless and would classify most of friends and family as homeless ☐ Friends, family or other people are placing security of housing at imminent risk, **or** impacting life, wellness, or safety ☐ In the past 90 days, left an exploitive, abusive or dependent relationship ☐ No friends or family and any family member demonstrates an inability to follow social norms
3	**Any** of the following: ☐ Currently homeless, and would classify some of friends as housed, while some are homeless ☐ In the past 90-180 days, left an exploitive, abusive or dependent relationship ☐ Friends, family or other people are having some negative consequences on wellness or housing stability ☐ No friends or family but all family members demonstrate ability to follow social norms ☐ Any family member is meeting new people with an intention of forming friendships ☐ Any family member is reconnecting with previous friends or family members, but experiencing difficulty advancing the relationship
2	**Any** of the following: ☐ Currently homeless, and would classify friends and family as being housed ☐ More than 180 days ago, left an exploitive, abusive or dependent relationship ☐ Any family member is developing relationships with new people but not yet fully trusting them
1	☐ Has been housed for less than 180 days, **and** family is engaged with friends or family, who are having no negative consequences on the individual's housing stability
0	☐ Has been housed for at least 180 days, **and** family is engaged with friends or family, who are having no negative consequences on the individual's housing stability

M. Self Care & Daily Living Skills of Family Head

PROMPTS	CLIENT SCORE:
• *Do you have any worries about taking care of yourself or your family?* • *Do you have any concerns about cooking, cleaning, laundry or anything like that?* • *Does anyone in your family ever need reminders to do things like shower or clean up?* • *Describe your family's last apartment.* • *Do you know how to shop for nutritious food on a budget?* • *Do you know how to make low cost meals that can result in leftovers to freeze or save for another day?* • *Do you tend to keep all of your family's clothes clean?* • *Have you ever had a problem with mice or other bugs like cockroaches as a result of a dirty apartment?* • *When you have had a place where you have made a meal, do you tend to clean up dishes and the like before they get crusty?*	**NOTES**

SCORING	
4	**Any** of the following for head(s) of household: ☐ No insight into how to care for themselves, their apartment or their surroundings ☐ Currently homeless and relies upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing) on an almost daily basis ☐ Engaged in hoarding or collecting behavior and is not aware that it is an issue in her/his life
3	**Any** of the following for head(s) of household: ☐ Has insight into some areas of how to care for themselves, their apartment or their surroundings, but misses other areas because of lack of insight ☐ In the past 180 days, relied upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing), 14+ days in any 30-day period ☐ Engaged in hoarding or collecting behavior and is aware that it is an issue in her/his life
2	**Any** of the following for head(s) of household: ☐ Fully aware and has insight in all that is required to take care of themselves, their apartment and their surroundings, but has not yet mastered the skills or time management to fully execute this on a regular basis ☐ In the past 180 days, relied upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing), fewer than 14 days in every 30-day period
1	☐ In the past 365 days, family accessed community resources 4 or fewer times, **and** head of household is fully taking care of all the family's daily needs
0	☐ For the past 365+ days, fully taking care of all the family's daily needs independently

N. Meaningful Daily Activity

PROMPTS	CLIENT SCORE:
• *How does your family spend their days?* • *How does your family spend their free time?* • *Do these things make your family feel happy/fulfilled?* • *How many days a week would you say members of your family have things to do that make them feel happy/fulfilled?* • *How much time in a week would you or members of your family say they are totally bored?* • *When people in your family wake up in the morning, do they tend to have an idea of what they plan to do that day?* • *How much time in a week would you say members of your family spend doing stuff to fill up the time rather than doing things that they love?* • *Are there any things that get in the way of your family doing the sorts of activities they would like to be doing?*	**NOTES**

SCORING	
4	☐ Any member of the family has no planned, legal activities described as providing fulfillment or happiness
3	☐ Any member of the family is discussing, exploring, signing up for and/or preparing for new activities or to re-engage with planned, legal activities that used to provide fulfillment or happiness
2	☐ Some members of the family are attempting new or re-engaging with planned, legal activities that used to provide fulfillment or happiness, but uncertain that activities selected are currently providing fulfillment or happiness, **or** they are not fully committed to continuing the activities.
1	☐ Each family member has planned, legal activities described as providing fulfillment or happiness 1-3 days per week
0	☐ Each family member has planned, legal activities described as providing fulfillment or happiness 4+ days per week

O. History of Homelessness & Housing

PROMPTS	CLIENT SCORE:
• *How long has your family been homeless?* • *How many times has your family experienced homelessness other than this most recent time?* • *Has your family spent any time sleeping on a friend's couch or floor? And if so, during those times did you consider that to be your family's permanent address?* • *Has your family ever spent time sleeping in a car, alleyway , garage, barn, bus shelter, or anything like that?* • *Has your family ever spent time sleeping in an abandoned building?* • *Was anyone in your family ever been in hospital or jail for a period of time when they didn't have a permanent address to go to when they got out?*	**NOTES**

SCORING	
4	☐ Over the past 10 years, cumulative total of 5+ years of family homelessness
3	☐ Over the past 10 years, cumulative total of 2+ years but fewer than 5 years of family homelessness
2	☐ Over the past 4 years, cumulative total of 30+ days but fewer than 2 years of family homelessness
1	☐ Over the past 4 years, cumulative total of 7+ days but fewer than 30 days of family homelessness
0	☐ Over the past 4 years, cumulative total of 7 or fewer days of family homelessness

P. Parental Engagement

PROMPTS	CLIENT SCORE:
• *Walk me through a typical evening after school in your family.* • *Tell me about what role, if any, the older kids have with the younger kids. Do they babysit? Walk them to school? Bathe or put the younger kids to bed?* • *Does your family have play time together? What kinds of things do you do and how often do you do it?* • *Let's pick a day like a Saturday...do you know where your kids are the entire day and whom they are out with all day?*	**NOTES**

Note: In this section, a child is considered "supervised" when the parent has knowledge of the child's whereabouts, the child is in an age-appropriate environment, and the child is engaged with the parent or another responsible adult. "Caretaking tasks" are tasks that may be expected by a parent/caregiver such as getting children to/from school, preparing meals, bathing children, putting children to bed, etc.

	SCORING
4	☐ No sense of parental attachment and responsibility ☐ No meaningful family time together ☐ Children 12 and younger are unsupervised 3+ hours each day ☐ Children 13 and older are unsupervised 4+ hours each day ☐ In families with 2+ children, the older child performs caretaking tasks 5+ days/week
3	☐ Weak sense of parental attachment and responsibility ☐ Meaningful family activities occur 1-4 times in a month ☐ Children 12 and younger are unsupervised 1-3 hours each day ☐ Children 13 and older are unsupervised 2-4 hours each day ☐ In families with 2+ children, the older child performs caretaking tasks 3-4 days/week
2	☐ Sense of parental attachment and responsibility, but not consistently applied ☐ Meaningful family activities occur 1-2 days per week ☐ Children 12 and younger are unsupervised fewer than 1 hour each day ☐ Children 13 and older are unsupervised 1-2 hours each day ☐ In families with 2+ children, the older child performs caretaking tasks fewer than 2 days/week
1	☐ Strong sense of parental attachment and responsibility towards their children ☐ Meaningful family activities occur 3-6 days of the week ☐ Children 12 and younger are never unsupervised ☐ Children 13 and older are unsupervised no more than an hour each day
0	☐ Strong sense of attachment and responsibility towards their children ☐ Meaningful family activities occur daily ☐ Children are never unsupervised

Q. Stability/Resiliency of the Family Unit

PROMPTS	CLIENT SCORE:
• *Over the past year have there been any different adults staying with the family like a family friend, grandparent, aunt or that sort of thing? If so, can you tell me when and for how long and the changes that have occurred?* • *Other than kids being taken into care, have there been any instances where any child has gone to stay with another family member or family friend for any length of time? Can you tell me how many times, when and for how long that happened?*	**NOTES**

SCORING	
4	In the past 365 days, **any** of the following have occurred: ☐ Parental arrangements and/or other adult relative within the family have changed 4+ times ☐ Children have left or returned to the family 4+ times
3	In the past 365 days, **any** of the following have occurred: ☐ Parental arrangements and/or other adult relatives within the family have changed 3 times ☐ Children have left or returned to the family 3 times
2	In the past 365 days, **any** of the following have occurred: ☐ Parental arrangements and/or other adult relatives within the family have changed 2 times ☐ Children have left or returned to the family 2 times
1	In the past 365 days, **any** of the following have occurred: ☐ Parental arrangements and/or other adult relatives within the family have changed 1 time ☐ Children have left or returned to the family 1 time
0	In the past 365 days, **any** of the following have occurred: ☐ No change in parental arrangements and/or other adult relatives within the family ☐ Children have not left or returned to the family

R. Needs of Children

PROMPTS	CLIENT SCORE:
• *Please tell me about the attendance at school of your school-aged children.* • *Any health issues with your children?* • *Any times of separation between your children and parents?* • *Without going into detail, have any of your children experienced or witnessed emotional, physical, sexual or psychological abuse?* • *Have your children ever accessed professional assistance to address that abuse?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ In the last 90 days, children needed to live with friends or family for 15+ days in any month ☐ School-aged children are not currently enrolled in school ☐ Any member of the family, including children, is currently escaping an abusive situation ☐ The family is homeless
3	**Any** of the following: ☐ In the last 90 days, children needed to live with friends or family for 7-14 days in any month ☐ School-aged children typically miss 3+ days of school per week for reasons other than illness ☐ In the last 180 days, any child(ren) in the family has experienced an abusive situation that has since ended
2	**Any** of the following: ☐ In the last 90 days, children needed to live with friends or family for 1-6 days in any month ☐ School-aged children typically miss 2 days of school per week for reasons other than illness ☐ In the past 365 days, any child(ren) in the family has experienced an abusive situation that has ended more than 180 days ago
1	**Any** of the following: ☐ In the last 365 days, children needed to live with friends or family for 7+ days in any month, but not in the last 90 days ☐ School-aged children typically miss 1 day of school per week for reasons other than illness
0	**All** of the following: ☐ In the last 365 days, children needed to live with friends or family for fewer than 7 days in every month ☐ School-aged children maintain consistent attendance at school ☐ There is no evidence of children in the home having experienced or witnessed abuse ☐ The family is housed

S. Size of Family Unit

PROMPTS	CLIENT SCORE:
• *I just want to make sure I understand how many kids there are, the gender of each and their age. Can you take me through that again?* • *Is anyone in the family currently pregnant?*	NOTES

SCORING	FOR ONE-PARENT FAMILIES:	FOR TWO-PARENT FAMILIES:
4	**Any** of the following: ☐ A pregnancy in the family ☐ At least one child aged 0-6 ☐ Three or more children of any age	**Any** of the following: ☐ A pregnancy in the family ☐ Four or more children of any age
3	**Any** of the following: ☐ At least one child aged 7-11 ☐ Two children of any age	**Any** of the following: ☐ At least one child aged 0-6 ☐ Three children of any age
2	☐ At least one child aged 12–15.	**Any** of the following: ☐ At least one child aged 7-11 ☐ Two children of any age
1	☐ At least one child aged 16 or older.	☐ At least one child aged 12 or older
0	☐ Children have been permanently removed from the family and the household is transitioning to services for singles or couples without children	

T. Interaction with Child Protective Services and/or Family Court

PROMPTS	CLIENT SCORE:
• *Any matters being considered by a judge right now as it pertains to any member of your family?* • *Have any of your children spent time in care? When was that? For how long were they in care? When did you get them back?* • *Has there ever been an investigation by someone in child welfare into the matters of your family?*	NOTES

SCORING	
4	**Any** of the following: ☐ In the past 90 days, interactions with child protective services have occurred ☐ In the past 365 days, one or more children have been removed from parent's custody that have **not** been reunited with the family at least four days per week ☐ There are issues still be decided or considered within family court
3	In the past 180 days, **any** of the following have occurred: ☐ Interactions with child protective services have occurred, but not within the past 90 days ☐ One or more children have been removed from parent's custody through child protective services (non-voluntary) **and** the child(ren) has been reunited with the family four or more days per week; ☐ Issues have been resolved in family court
2	☐ In the past 365 days, interactions with child protective services have occurred, but not within the past 180 days, and there are no active issues, concerns or investigations
1	☐ No interactions with child protective services have occurred, within the past 365 days, and there are no active issues, concerns or investigations.
0	☐ There have been no serious interactions with child protective services because of parenting concerns

Client:	Worker:	Version:	Date:

COMPONENT	SCORE	COMMENTS
MENTAL HEALTH & WELLNESS AND COGNITIVE FUNCTIONING		
PHYSICAL HEALTH & WELLNESS		
MEDICATION		
SUBSTANCE USE		
EXPERIENCE OF ABUSE AND/ OR TRAUMA		
RISK OF HARM TO SELF OR OTHERS		
INVOLVEMENT IN HIGHER RISK AND/OR EXPLOITIVE SITUATIONS		
INTERACTION WITH EMERGENCY SERVICES		

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Client:	Worker:	Version:	Date:

COMPONENT	SCORE	COMMENTS
LEGAL INVOLVEMENT		
MANAGING TENANCY		
PERSONAL ADMINISTRATION & MONEY MANAGEMENT		
SOCIAL RELATIONSHIPS & NETWORKS		
SELF-CARE & DAILY LIVING SKILLS		
MEANINGFUL DAILY ACTIVITIES		
HISTORY OF HOUSING & HOMELESSNESS		

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Client:	Worker:	Version:	Date:

COMPONENT	SCORE	COMMENTS
PARENTAL ENGAGEMENT		
STABILITY/RESILIENCY OF THE FAMILY UNIT		
NEEDS OF CHILDREN		
SIZE OF FAMILY		
INTERACTION WITH CHILD PROTECTIVE SERVICES AND/ OR FAMILY COURT		
TOTAL		**Score: Recommendation:** 0-26: No housing intervention 27-53: Rapid Re-Housing 54-80: Permanent Supportive Housing/Housing First

Appendix A: About the SPDAT

OrgCode Consulting, Inc. is pleased to announce the release of Version 4 of the Service Prioritization Decision Assistance Tool (SPDAT). Since its release in 2010, the SPDAT has been used with over 10,000 unique individuals in over 100 communities across North America and in select locations around the world.

Originally designed as a tool to help prioritize housing services for homeless individuals based upon their acuity, the SPDAT has been successfully adapted to other fields of practice, including: discharge planning from hospitals, work with youth, survivors of domestic violence, health research, planning supports for consumer survivors of psychiatric care systems, and in work supporting people with fetal alcohol spectrum disorders. We are encouraged that so many service providers and communities are expanding the use of this tool, and OrgCode will continue to support the innovative use of the SPDAT to meet local needs.

SPDAT Design

The SPDAT is designed to:

- Help prioritize which clients should receive what type of housing assistance intervention, and assist in determining the intensity of case management services
- Prioritize the sequence of clients receiving those services
- Help prioritize the time and resources of Frontline Workers
- Allow Team Leaders and program supervisors to better match client needs to the strengths of specific Frontline Workers on their team
- Assist Team Leaders and program supervisors to support Frontline Workers and establish service priorities across their team
- Provide assistance with case planning and encourage reflection on the prioritization of different elements within a case plan
- Track the depth of need and service responses to clients over time

The SPDAT is NOT designed to:

- Provide a diagnosis
- Assess current risk or be a predictive index for future risk
- Take the place of other valid and reliable instruments used in clinical research and care

The SPDAT is only used with those clients who meet program eligibility criteria. For example, if there is an eligibility criterion that requires prospective clients to be homeless at time of intake to be eligible for Housing First, then the pre-condition must be met before pursuing the application of the SPDAT. For that reason, we have also created the VI-SPDAT as an initial screening tool.

The SPDAT is not intended to replace clinical expertise or clinical assessment tools. The tool complements existing clinical approaches by incorporating a wide array of components that provide both a global and detailed picture of a client's acuity. Certain components of the SPDAT relate to clinical concerns, and it is expected that intake professionals and clinicians will work together to ensure the accurate assessment of these issues. In fact, many organizations and communities have found the SPDAT to be a useful method for bridging the gap between housing, social services and clinical services.

Family SPDAT

Upon the release of SPDAT Version 3, a special version was released - the Family SPDAT Version 1. This tool introduced five new components that specifically address the unique challenges to housing stability faced by homeless families. In addition, the tool has a focus on households throughout.

SPDAT Version 4/Family SPDAT Version 2

The SPDAT has been influenced by the experience of practitioners in its use, persons with lived experience that have had the SPDAT implemented with them, as well as a number of other excellent tools such as (but not limited to) the Outcome Star, Health of the Nation Outcome Scale, Denver Acuity Scale, Camberwell Assessment of Needs, Vulnerability Index, and Transition Aged Youth Triage Tool.

In preparing SPDAT v4 and F-SPDAT v2, we have adopted a comprehensive and collaborative approach to changing and improving the SPDAT. Communities that have used the tool for three months or more have provided us with their feedback. OrgCode staff have observed the tool in operation to better understand its implementation in the field. An independent committee composed of service practitioners and academics review enhancements to the SPDAT. Furthermore, we continue to test the validity of SPDAT results through the use of control groups. Overall, we consistently see that groups assessed with the SPDAT have better long-term housing and life stability outcomes than those assessed with other tools, or no tools at all.

OrgCode intends to continue working with communities and persons with lived experience to make future versions of the SPDAT even better. We hope all those communities and agencies that choose to use this tool will remain committed to collaborating with us to make those improvements over time.

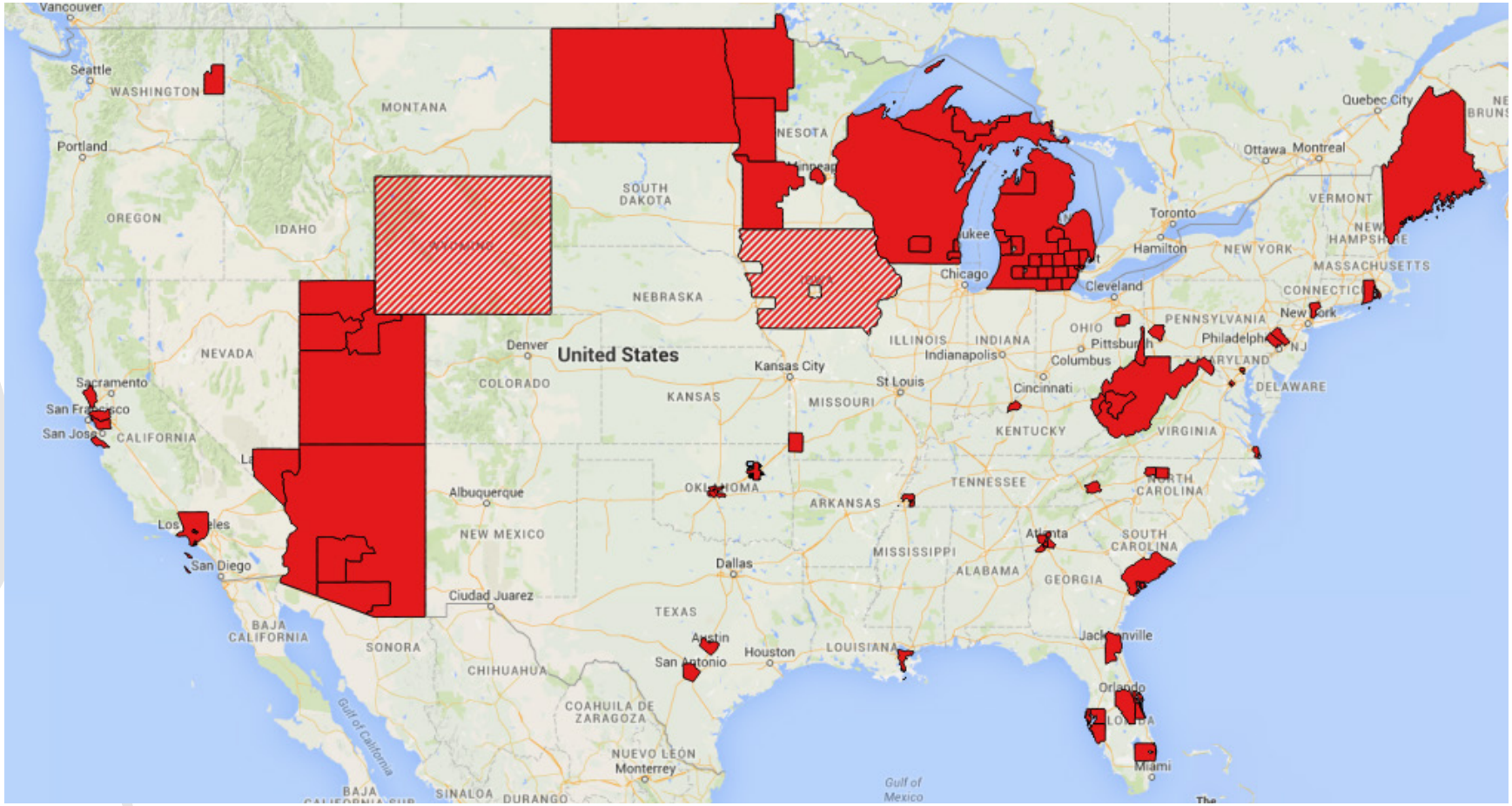
The new versions build upon the success of previous versions of the SPDAT products with some refinements. Starting in August 2014, a survey was launched of existing SPDAT and F-SPDAT users to get their input on what should be amended, improved, or maintained in the tool. Analysis was completed across all of these responses. Further research was conducted. Questions were tested and refined over several months, again including the direct voice of persons with lived experience and frontline practitioners. Input was also gathered from senior government officials that create policy and programs to help ensure alignment with guidelines and funding requirements.

The major differences from F-SPDAT Version 1 to Version 2 include:

- The structure of the tools is the same: four domains (five for families) with components aligned to specific domains. The names of the domains and the components remain unchanged.
- The scoring of the tools is the same: 60 points for singles, and 80 points for families.
- The scoring tables used to run from 0 through to 4. They are now reversed with each table starting at 4 and working their way down to 0. This increases the speed of assessment.
- The order of the tools has changed, grouped together by domain.
- Language has been simplified.
- Days are used rather than months to provide greater clarification and alignment to how most databases capture periods of time in service.
- Greater specificity has been provided in some components such as amount of debts.

Appendix B: Where the SPDAT is being used (as of May 2015)

United States of America



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Arizona
- Statewide

California
- Oakland/Alameda County CoC
- Richmond/Contra Costa County CoC
- Watsonville/Santa Cruz City & County CoC
- Napa City & County CoC
- Los Angeles City & County CoC
- Pasadena CoC
- Glendale CoC

District of Columbia
- District of Columbia CoC

Florida
- Sarasota/Bradenton/Manatee, Sarasota Counties CoC
- Tampa/Hillsborough County CoC
- St. Petersburg/Clearwater/Largo/Pinellas County CoC
- Orlando/Orange, Osceola, Seminole Counties CoC
- Jacksonville-Duval, Clay Counties CoC
- Palm Bay/Melbourne/Brevard County CoC
- West Palm Beach/Palm Beach County CoC

Georgia
- Atlanta County CoC
- Fulton County CoC
- Marietta/Cobb County CoC
- DeKalb County CoC

Iowa
- Parts of Iowa Balance of State CoC

Kentucky
- Louisville/Jefferson County CoC

Louisiana
- New Orleans/Jefferson Parish CoC

Maryland
- Baltimore City CoC

Maine
- Statewide

Michigan
- Statewide

Minnesota
- Minneapolis/Hennepin County CoC
- Northwest Minnesota CoC
- Moorhead/West Central Minnesota CoC
- Southwest Minnesota CoC

Missouri
- Joplin/Jasper, Newton Counties CoC

North Carolina
- Winston Salem/Forsyth County CoC
- Asheville/Buncombe County CoC
- Greensboro/High Point CoC

North Dakota
- Statewide

Nevada
- Las Vegas/Clark County CoC

New York
- Yonkers/Mount Vernon/New Rochelle/Westchester County CoC

Ohio
- Canton/Massillon/Alliance/Stark County CoC
- Toledo/Lucas County CoC

Oklahoma
- Tulsa City & County/Broken Arrow CoC
- Oklahoma City CoC

Pennsylvania
- Lower Marion/Norristown/Abington/Montgomery County CoC
- Bristol/Bensalem/Bucks County CoC
- Pittsburgh/McKeesport/Penn Hills/Allegheny County CoC

Rhode Island
- Statewide

South Carolina
- Charleston/Low Country CoC

Tennessee
- Memphis/Shelby County CoC

Texas
- San Antonio/Bexar County CoC
- Austin/Travis County CoC

Utah
- Salt Lake City & County CoC
- Utah Balance of State CoC
- Provo/Mountainland CoC

Virginia
- Virginia Beach CoC
- Arlington County CoC

Washington
- Spokane City & County CoC

Wisconsin
- Statewide

West Virginia
- Statewide

Wyoming
- Wyoming is in the process of implementing statewide

Canada

Alberta
- Province-wide

Manitoba
- City of Winnipeg

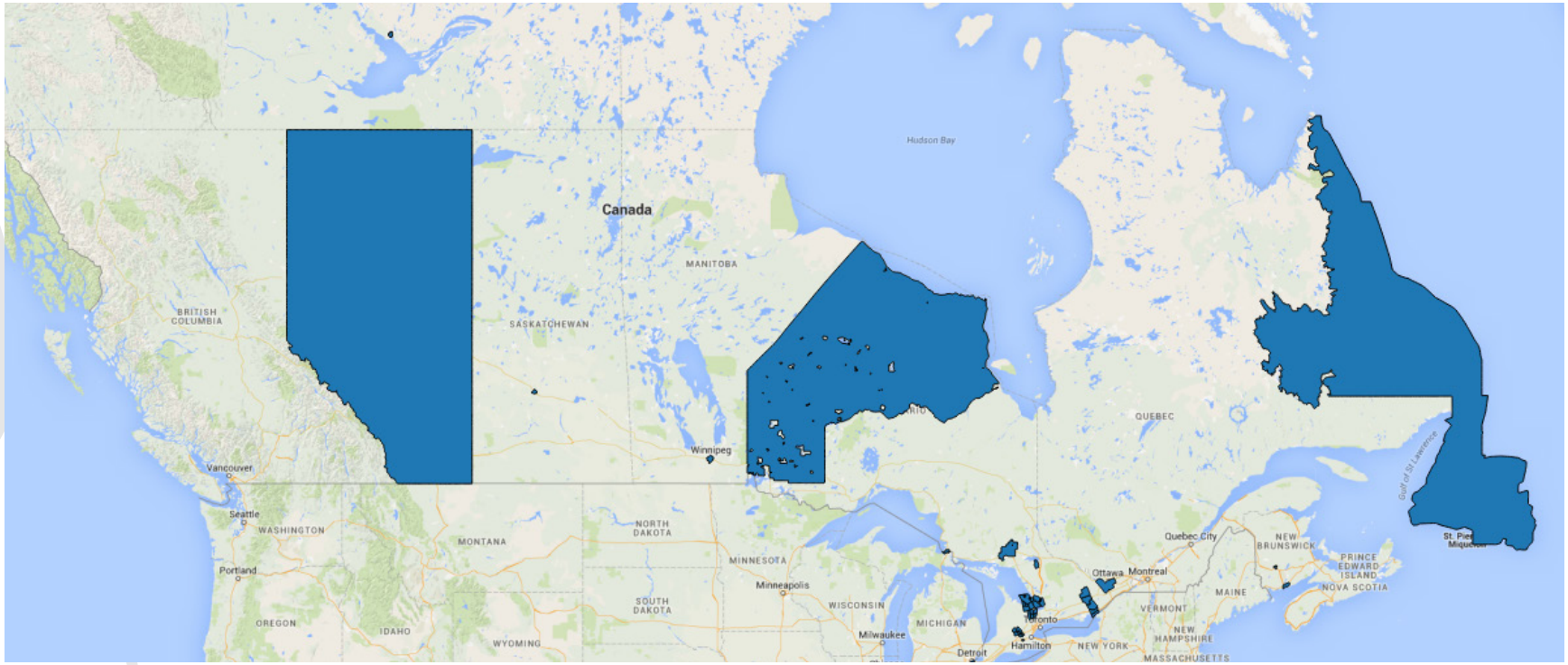
New Brunswick
- City of Fredericton
- City of Saint John

Newfoundland and Labrador
- Province-wide

Northwest Territories
- City of Yellowknife

Ontario
- City of Barrie/Simcoe County
- City of Brantford/Brant County
- City of Greater Sudbury
- City of Kingston/Frontenac County
- City of Ottawa
- City of Windsor
- District of Kenora
- District of Parry Sound
- District of Sault Ste Marie
- Regional Municipality of Waterloo
- Regional Municipality of York

Saskatchewan
- Saskatoon



Australia

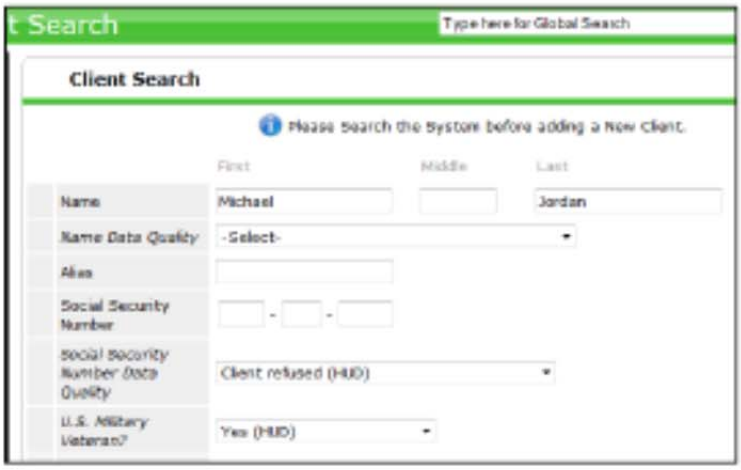
Queensland
- Brisbane

Appendix D: Adding Anonymous Client into HMIS

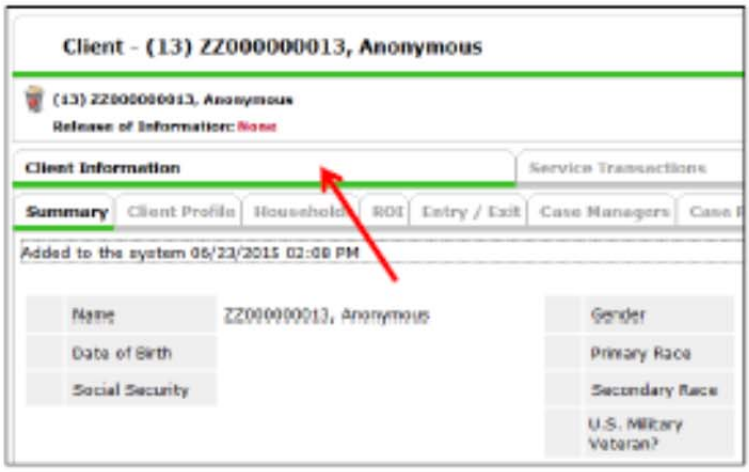
In the event that a client's information cannot be entered into HMIS, users can enter a new client anonymously. The process is quick and simple. The most important thing to remember is to immediately record the client ID number.

Begin by responding to the Social Security and Veteran questions. These need to be collected for every client, both known and anonymous.

- Social Security: select "Client refused"
- Veteran: answer appropriately



After clicking "Add Anonymous Client," the client's name disappears, and an anonymous ID takes its place. **Record this immediately.**



Enter the client's record as usual. Members of the household can also be entered anonymously, using the same process. Again, **record the household members' ID numbers immediately.**

Like identifiable clients, anonymous clients should have a complete HUD UDE assessment, with no missing data.

Appendix E: Coordinated Assessment Metrics

Process Metrics

- Number of assessments completed
- Number of assessments completed weekly at each site/by each assessment staff member
- Percent of households receiving diversion assistance
- Number of households receiving diversion assistance
- Percent of households receiving prevention assistance
- Number of households receiving prevention assistance
- Percent of declined referrals (provider)
- Number of declined referrals (provider)
- Percent of decline referrals (consumer)
- Number of declined referrals (consumer)
- Average amount of time spent per assessment
- Number of complaints filed with Coordinated Assessment Committee (provider)
- Number of complaints filed with Coordinated Assessment Committee (consumer)
- Average wait time for an assessment

Outcome Measures

- Percent of households exiting from homelessness to permanent housing
- Number of households exiting from homelessness to permanent housing
- Percent of households diverted but requesting shelter placement within 12 months
- Number of households diverted but requesting shelter placement within 12 months
- Average length of episodes of homelessness
- Number of repeat entries into homelessness
- Number of new entries into homelessness

Appendix F: Sample Questions for Consumer Survey

1. Where did you first go for help when you became homeless?
    a. Family or friends
    b. Church, mosque, temple, or other religious entity
    c. Emergency shelter or other housing provider
    d. State agency (Department of Human Services, Health Department, etc)
    e. Other, please explain:

2. If you received services from an emergency shelter or other housing provider, which one?

3. How did you find out about that program or place?
    a. Television
    b. Radio
    c. Newspaper
    d. Agency website
    e. Social media
    f. Referral
    g. Word of mouth
    h. Other, please explain

4. What made you decide to go that shelter when you became homeless? (Select all that apply.)
    a. Agency provides the service(s) I need
    b. Convenience
    c. I was referred there by another agency
    d. People I know have received services there
    e. I've used this agency's services before
    f. Agency's reputation
    g. I didn't know where else to go
    h. Other, please explain

5. How did that agency help you once they found out you were homeless?
    a. Emergency shelter/referral for emergency shelter
    b. Transitional housing/referral for transitional housing
    c. Permanent supportive housing/referral for permanent supportive housing
    d. Case management
    e. Food pantry
    f. Substance abuse counseling/referral
    g. Domestic violence counseling/referral
    h. Mental health counseling/referral
    i. Other, please explain

6. Was the agency easy for you to get to?
    a. Yes
    b. No, please explain

7. Would you recommend going to that place to someone else that became homeless? Why or why not?
    a. Yes, please explain
    b. No, please explain

8. If you needed a place to sleep that night, did you get it?
    a. Yes
    b. No, please explain

9. Were you happy with what happened after your intake assessment (the “getting to know you” questions they asked) was finished?
    a. Yes
    b. No, please explain

10. Did the process of acquiring or placement into housing make sense to you?
    a. Yes
    b. No, please explain

11. Did the process of acquiring or placement into housing help you meet your housing needs?
    a. Yes
    b. No, please explain

12. Did you and your case manager create a plan for returning to permanent housing?
    a. Yes
    b. No, please explain

13. What other thoughts would you like to share with us?

Certified as approved by West Central Illinois Continuum of Care Consortium's governing board, West Central Illinois (WCI) Homeless Assistance Council on November 6, 2015.

Lori A. Sutton, Support Entity

Revision history: original version approved September 3, 2015 by West Central Illinois Continuum of Care Consortium's Coordinated Assessment Workgroup.

Revised 10/9/2015 approved by Coordinated Assessment Workgroup.