



COHMIS Client Consent for Data Collection and Release of Information

This notice explains how information about you may be shared and used. It also tells you who can access your information. Please read it carefully and ask any questions you may have.

What is COHMIS?

The Colorado Homeless Management Information System (COHMIS) is a data system that stores information about homelessness services. The name of the software that stores this data is called Clarity Human Services. The purpose of COHMIS is to improve coordination of services that support people who are homeless or at risk of homelessness. To further ensure and navigate this coordination, data is shared statewide between the four Continuum of Care (CoC) bodies: MDHI (Metro Denver), Pikes Peak (El Paso County) Northern Colorado (Larimer and Weld Counties), and Balance of State (Remaining 54 Counties). Active agencies that participate in COHMIS are listed on <https://cohmis.zendesk.com/hc/en-us>.

What is the purpose of this form?

With this form, you can give permission to have information about you collected and shared with partner agencies that help provide housing and services. Partner agencies are required to protect the privacy of your identifying information.

You have rights regarding your information:

- You have the right to ask about who has seen your information.
- You have the right to see your information at any time and change it if it isn't correct.
- You have the right to change your authorization regarding the use of your data.
- You have the right to file a grievance if you feel your information has been misused. The Grievance Form may be requested at any time from any participating COHMIS agency.
- Right to refuse information while retaining rights of access to services.

The information to be collected and shared may include:

- Name, date of birth, gender, race, ethnicity, social security number, phone number, address
- Basic medical, mental health, substance use and daily living information
- Housing and program eligibility information
- Use of crisis services, Veteran services, hospitals and jail
- Employment, income, insurance and benefits information
- Services provided by partner agencies
- Results from assessments
- Photograph or other likeness (if included)

By signing this form:

- I authorize the CoC and Clarity to share COHMIS information with partner agencies, and the COHMIS information shared will be used to coordinate services. It will also be used to help evaluate the quality of community programs.
- I understand that the partner agencies may change over time and are always responsible for keeping my information private using reasonable best efforts for privacy policies.
- I understand that agencies must adhere to federal and Colorado laws regarding my protected information.
- I may revoke this consent at any time by returning a completed revocation of consent form, available upon request, to agency staff.
- I can receive a copy of this consent form.
- I understand this consent will expire 7 years from my last COHMIS recorded activity.

Printed Name of Client or Legal Guardian: _____

Printed Names of additional minor children covered by this release: _____

Signature of Client or Representative: _____ Date: _____

Signature of Agency Witness: _____ Date: _____

_____ *Initials of Client If Declining Consent*



COHMIS Intake

CoC/ESG Intake Form for Project Types:

COHMIS Permanent Housing (PSH, PH, RRH), Homelessness Prevention, Transitional Housing, Services Only

SOCIAL SECURITY NUMBER (SSN):										
Quality of SSN:		<input type="checkbox"/> Full SSN Reported			<input type="checkbox"/> Client doesn't know					
		<input type="checkbox"/> Approximate or partial SSN reported			<input type="checkbox"/> Client prefers not to answer			<input type="checkbox"/> Data not collected		
CLIENT NAME										
Last:										
First:										
Middle					Suffix:					
QUALITY OF NAME		<input type="checkbox"/> Full name reported			<input type="checkbox"/> Client doesn't know					
		<input type="checkbox"/> Partial, street name or code name reported			<input type="checkbox"/> Client prefers not to answer			<input type="checkbox"/> Data not collected		
DATE OF BIRTH (DOB)										
		MONTH		DAY		YEAR				
QUALITY OF DOB		<input type="checkbox"/> Full DOB reported			<input type="checkbox"/> Client doesn't know					
		<input type="checkbox"/> Approximate or partial DOB reported			<input type="checkbox"/> Client prefers not to answer			<input type="checkbox"/> Data not collected		
GENDER (select all that apply)										
<input type="checkbox"/> Woman (Girl if child)			<input type="checkbox"/> Non-binary			<input type="checkbox"/> Client doesn't know				
<input type="checkbox"/> Man (Boy if child)			<input type="checkbox"/> Questioning			<input type="checkbox"/> Client prefers not to answer				
<input type="checkbox"/> Culturally Specific Identity (e.g., Two Spirit)			<input type="checkbox"/> Different Identity			<input type="checkbox"/> Data not collected				
<input type="checkbox"/> Transgender										
If different identity, please specify: _____										
CLIENT PRONOUNS										
<input type="checkbox"/> She/Her/Hers		<input type="checkbox"/> They/Them/Theirs		<input type="checkbox"/> Client prefers not to answer		<input type="checkbox"/> Other pronouns: _____				
<input type="checkbox"/> He/Him/His		<input type="checkbox"/> Client doesn't know		<input type="checkbox"/> Data not collected						
RACE/ETHNICITY (select all that apply)										
<input type="checkbox"/> American Indian, Alaska Native, or Indigenous			<input type="checkbox"/> Hispanic/Latina/e/o			<input type="checkbox"/> Client doesn't know				
<input type="checkbox"/> Asian or Asian American			<input type="checkbox"/> Middle Eastern or North African			<input type="checkbox"/> Client prefers not to answer				
<input type="checkbox"/> Black, African American, or African			<input type="checkbox"/> Native Hawaiian or Pacific Islander			<input type="checkbox"/> Data not collected				
			<input type="checkbox"/> White							
Additional Race and Ethnicity Detail (optional): _____										
VETERAN STATUS										
<input type="checkbox"/> Yes*		<input type="checkbox"/> Client doesn't know								
<input type="checkbox"/> No		<input type="checkbox"/> Client prefers not to answer								
*If YES, complete the Veteran Supplemental Questions		<input type="checkbox"/> Data not collected								
RELATIONSHIP TO HEAD OF HOUSEHOLD										
<input type="checkbox"/> Self (Head of Household)				<input type="checkbox"/> Head of household's other relation member						
<input type="checkbox"/> Head of Household's Child				<input type="checkbox"/> Other: nonrelation member						
<input type="checkbox"/> Head of Household's spouse or partner										

PROJECT NAME											
PROJECT START DATE (mm/dd/yyyy)				—			—				
Housing move-in Date (PH ONLY)							Zip Code:				
Translation assistance needed?		<input type="checkbox"/> No <input type="checkbox"/> Yes*			<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected						
If *YES, to the question above, Preferred Language:		Specify Language: _____			<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected						
PRIOR LIVING SITUATION (Where did the client sleep the night before entering this project?) <u>PICK ONLY 1 SITUATION CATEGORY (homeless, institutional, OR temp/permanent) AND COMPLETE THAT SECTION</u>											
HOMELESS SITUATION											
<input type="checkbox"/> Place not meant for human habitation (vehicle, anywhere outside) <input type="checkbox"/> Emergency shelter, including hotel or motel paid for w/ emergency shelter voucher or RHY-funded host home <input type="checkbox"/> Safe Haven											
LENGTH OF STAY IN PRIOR LIVING SITUATION (How long did the client stay in that situation?)											
<input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> One month or more, but less than 90 days <input type="checkbox"/> 90 days or more, but less than one year <input type="checkbox"/> One year or longer <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected											
Approximate date THIS EPISODE of homelessness started:				—			—				
		MONTH			DAY			YEAR			
Number of times the client has been on the streets, in ES, or SH in the past three years, including today (Regardless of where they stayed last night)											
<input type="checkbox"/> One time <input type="checkbox"/> Two times <input type="checkbox"/> Three times <input type="checkbox"/> Four or more times <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected											
Total number of months homeless on the street, in ES, or SH in the past three years											
<input type="checkbox"/> One month (first month) <input type="checkbox"/> Two months <input type="checkbox"/> Three months <input type="checkbox"/> Four months <input type="checkbox"/> Five months <input type="checkbox"/> Six months <input type="checkbox"/> Seven months <input type="checkbox"/> Eight months <input type="checkbox"/> Nine months <input type="checkbox"/> Ten months <input type="checkbox"/> Eleven months <input type="checkbox"/> Twelve months <input type="checkbox"/> More than 12 months <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected											
<i>End of section</i>											

Homeless Situation Section

INSTITUTIONAL SITUATION									
<input type="checkbox"/> Foster care home or foster care group home		<input type="checkbox"/> Long-term care facility or nursing home		<input type="checkbox"/> Hospital or other residential non-psychiatric medical facility		<input type="checkbox"/> Psychiatric hospital or other psychiatric facility		<input type="checkbox"/> Substance abuse treatment facility or detox center	
<input type="checkbox"/> Jail, prison, or juvenile detention facility									
LENGTH OF STAY IN PRIOR LIVING SITUATION <i>(How long did the client stay in that situation?)</i>									
<input type="checkbox"/> One night or less		<input type="checkbox"/> One month or more, but less than 90 days		<input type="checkbox"/> Client doesn't know		<input type="checkbox"/> Client prefers not to answer		<input type="checkbox"/> Data not collected	
<input type="checkbox"/> Two to six nights		<input type="checkbox"/> 90 days or more, but less than one year		<input type="checkbox"/> One year or longer					
<input type="checkbox"/> One week or more, but less than one month									
Length of Stay Less than 90 days? <i>(Indicate if the client's stay in the Institutional setting, where they stayed last night/prior to project entry, was less than 90 days)</i>								<input type="checkbox"/> No <input type="checkbox"/> Yes*	
If YES to the question above, continue. If NO, stop here. On the night before the client entered the institutional living situation, were they staying in a homeless situation <i>(emergency shelter, place not meant for habitation or safe haven)?</i>								<input type="checkbox"/> No <input type="checkbox"/> Yes	
*If YES to the question above, continue. If NO, stop here.									
Approximate date THIS EPISODE of homelessness started:			—			—			
			MONTH	DAY		YEAR			
Number of times the client has been on the streets, in ES, or SH in the past three years, including today <i>(Regardless of where they stayed last night)</i>									
<input type="checkbox"/> One time		<input type="checkbox"/> Three times		<input type="checkbox"/> Client doesn't know		<input type="checkbox"/> Data not collected			
<input type="checkbox"/> Two times		<input type="checkbox"/> Four or more times		<input type="checkbox"/> Client prefers not to answer					
Total number of months homeless on the street, in ES, or SH in the past three years									
<input type="checkbox"/> One month (first month)		<input type="checkbox"/> Five months		<input type="checkbox"/> Nine months		<input type="checkbox"/> More than 12 months			
<input type="checkbox"/> Two months		<input type="checkbox"/> Six months		<input type="checkbox"/> Ten months		<input type="checkbox"/> Client doesn't know			
<input type="checkbox"/> Three months		<input type="checkbox"/> Seven months		<input type="checkbox"/> Eleven months		<input type="checkbox"/> Client prefers not to answer			
<input type="checkbox"/> Four months		<input type="checkbox"/> Eight months		<input type="checkbox"/> Twelve months		<input type="checkbox"/> Data not collected			
<i>End of section</i>									

TEMPORARY & PERMANENT HOUSING SITUATIONS

<input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Staying or living in a friend's room, apartment, or house <input type="checkbox"/> Staying or living in a family member's room, apartment, or house <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with ongoing housing subsidy* <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy	If rental with subsidy, specify Subsidy Type: <input type="checkbox"/> GPD TIP subsidy <input type="checkbox"/> VASH housing subsidy <input type="checkbox"/> RRH or equivalent subsidy <input type="checkbox"/> HCV voucher (tenant or project based) <input type="checkbox"/> Public housing unit <input type="checkbox"/> Emergency Housing Voucher <input type="checkbox"/> Family Unification Program Voucher (FUP) <input type="checkbox"/> Foster Youth to Independent Initiative (FYI) <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Other ongoing housing subsidy <input type="checkbox"/> Other permanent housing dedicated for formerly homeless persons <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
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LENGTH OF STAY IN PRIOR LIVING SITUATION *(How long did the client stay in that situation?)*

<input type="checkbox"/> One night or less	<input type="checkbox"/> One month or more, but less than 90 days	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Two to six nights	<input type="checkbox"/> 90 days or more, but less than one year	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> One week or more, but less than one month	<input type="checkbox"/> One year or longer	<input type="checkbox"/> Data not collected

Length of Stay Less than 7 days?

(Indicate if the client's stay in the transitional/permanent housing setting, where they stayed last night/prior to project entry, was less than 7 days)

 No
 Yes*

***If YES to the question above, continue. If NO, stop here.**

On the night before the client entered the transitional or permanent housing situation, were they staying in a homeless situation *(emergency shelter, place not meant for habitation or safe haven)*?

 No
 Yes*

***If YES to the question above, continue. If NO, stop here.**

Approximate date THIS EPISODE of homelessness started:

	—		
		—	
MONTH		DAY	
YEAR			

Number of times the client has been on the streets, in ES, or SH in the past three years, including today *(Regardless of where they stayed last night)*

<input type="checkbox"/> One time	<input type="checkbox"/> Three times	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Data not collected
<input type="checkbox"/> Two times	<input type="checkbox"/> Four or more times	<input type="checkbox"/> Client prefers not to answer	

Total number of months homeless on the street, in ES, or SH in the past three years

<input type="checkbox"/> One month (first month)	<input type="checkbox"/> Five months	<input type="checkbox"/> Nine months	<input type="checkbox"/> More than 12 months
<input type="checkbox"/> Two months	<input type="checkbox"/> Six months	<input type="checkbox"/> Ten months	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Three months	<input type="checkbox"/> Seven months	<input type="checkbox"/> Eleven months	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Four months	<input type="checkbox"/> Eight months	<input type="checkbox"/> Twelve months	<input type="checkbox"/> Data not collected

End of section

Temporary/Permanent Situation Section

Disabling Condition		
<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Yes	<input type="checkbox"/> Data not collected	
Physical Disability		
<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Yes*	<input type="checkbox"/> Data not collected	
*If YES for Physical Disability <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Yes	<input type="checkbox"/> Client prefers not to answer
		<input type="checkbox"/> Data not collected
Developmental Disability		
<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Yes	<input type="checkbox"/> Data not collected	
Chronic Health Condition		
<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Yes*	<input type="checkbox"/> Data not collected	
*If YES for Chronic Health Condition <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Yes	<input type="checkbox"/> Client prefers not to answer
		<input type="checkbox"/> Data not collected
HIV/AIDS		
<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Yes	<input type="checkbox"/> Data not collected	
Mental Health Disorder		
<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Yes*	<input type="checkbox"/> Data not collected	
*If YES for Mental Health Disorder <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Yes	<input type="checkbox"/> Client prefers not to answer
		<input type="checkbox"/> Data not collected
Substance Use Disorder		
<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Alcohol Use Disorder*	<input type="checkbox"/> Data not collected	
<input type="checkbox"/> Drug Use Disorder*		
<input type="checkbox"/> Both Alcohol and Drug Use Disorder*		
*If YES for Substance Use Disorder <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Yes	<input type="checkbox"/> Client prefers not to answer
		<input type="checkbox"/> Data not collected

SURVIVOR OF DOMESTIC VIOLENCE

- No
- Yes*

- Client doesn't know
- Client prefers not to answer
- Data not collected

***If YES to Survivor Domestic Violence**

When did this experience occur?	<input type="checkbox"/> Within the past three months <input type="checkbox"/> Three to six months ago (excluding six months exactly) <input type="checkbox"/> From six to twelve months ago (excluding one year exactly) <input type="checkbox"/> More than a year ago	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
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Are you currently fleeing?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
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CASH INCOME FOR INDIVIDUAL

Income from Any Source?	<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
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***If YES to Income from Any Source – Indicate all sources that apply**

Income Source (Check all that apply)	Monthly Amount
<input type="checkbox"/> Earned Income (i.e. employment income)	
<input type="checkbox"/> Unemployment Insurance	
<input type="checkbox"/> Supplemental Security Income (SSI)	
<input type="checkbox"/> Social Security Disability Insurance (SSDI)	
<input type="checkbox"/> VA Service-Connected Disability Compensation	
<input type="checkbox"/> VA Non-Service Connected Disability Pension	
<input type="checkbox"/> Private disability insurance	
<input type="checkbox"/> Worker's Compensation	
<input type="checkbox"/> Temporary Assistance for Needy Families (TANF)	
<input type="checkbox"/> General Assistance (GA)	
<input type="checkbox"/> Retirement Income from Social Security	
<input type="checkbox"/> Pension or retirement income from a former job	
<input type="checkbox"/> Child support	
<input type="checkbox"/> Alimony and other spousal support	
<input type="checkbox"/> Other Cash Income (Specify: _____)	
Total Monthly Amount	

NON-CASH BENEFITS

Receiving Non-Cash Benefits?	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Yes*	<input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected

***If YES to Receiving Non-Cash Benefits – Indicate all sources that apply**

<input type="checkbox"/> Supplemental Nutrition Assistance Program	<input type="checkbox"/> TANF Transportation Services
<input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	<input type="checkbox"/> Other TANF-Funded Services
<input type="checkbox"/> TANF Childcare Services	<input type="checkbox"/> Other Non-Cash Benefit (Specify source: _____)

HEALTH INSURANCE

Covered by health insurance?	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Yes*	<input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected

***If YES to Covered by Health Insurance – Indicate all sources that apply**

<input type="checkbox"/> Medicaid	<input type="checkbox"/> Health Insurance Obtained Through COBRA
<input type="checkbox"/> Medicare	<input type="checkbox"/> Private Pay Health Insurance
<input type="checkbox"/> State Children's Health Insurance Program	<input type="checkbox"/> State Health Insurance for Adults
<input type="checkbox"/> Veteran's Health Administration (VHA)	<input type="checkbox"/> Indian Health Services Program
<input type="checkbox"/> Employer-Provided Health Insurance	<input type="checkbox"/> Other Health Insurance (Specify source: _____)

Would you like to share the reasons or factors you feel contributed to your homelessness?	<input type="checkbox"/> No	<input type="checkbox"/> Yes*
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***If YES please indicate all reasons that apply**

<input type="checkbox"/> Abuse or violence in my home	<input type="checkbox"/> Lost a job, could not find work
<input type="checkbox"/> Alcohol or substance use problems	<input type="checkbox"/> Medical Expenses
<input type="checkbox"/> Asked to leave or evicted	<input type="checkbox"/> Mental health condition
<input type="checkbox"/> Bad credit	<input type="checkbox"/> Moved to find work
<input type="checkbox"/> Client Choice	<input type="checkbox"/> Problems with public benefits
<input type="checkbox"/> COVID-19	<input type="checkbox"/> PTSD
<input type="checkbox"/> Disabling conditions	<input type="checkbox"/> Reasons related to my race or ethnicity
<input type="checkbox"/> Discharged from foster care	<input type="checkbox"/> Reasons related to my sexual orientation or gender
<input type="checkbox"/> Discharged from jail	<input type="checkbox"/> Relationship problems or family breakup
<input type="checkbox"/> Discharged from prison	<input type="checkbox"/> Traumatic brain injury
<input type="checkbox"/> Family member or personal illness	<input type="checkbox"/> Unable to pay rent or mortgage
<input type="checkbox"/> Language barrier	<input type="checkbox"/> Unable to pay utilities
<input type="checkbox"/> Legal problems	<input type="checkbox"/> Other

SEXUAL ORIENTATION (REQUIRED FOR PSH, OPTIONAL FOR OTHER PROJECT TYPES)

<input type="checkbox"/> Heterosexual	<input type="checkbox"/> Bisexual	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Gay	<input type="checkbox"/> Questioning/Unsure	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Lesbian	<input type="checkbox"/> Other	<input type="checkbox"/> Data not collected

If other, please specify: _____

CONTACT INFORMATION (Optional — entered on the Contacts tab) <input type="checkbox"/> Personal <input type="checkbox"/> Work <input type="checkbox"/> Message	
Phone Number	
Email	

ADDRESS (Optional — entered on the Locations tab) <input type="checkbox"/> Current Address <input type="checkbox"/> Last Permanent Address <input type="checkbox"/> Mailing Address			
Street			
City			
State		Zip Code	

Signature of applicant stating all information is true and correct

Date



COHMIS

Child Intake Form

For all non-RHY funded projects

SOCIAL SECURITY NUMBER (SSN):													—				—		
Quality of SSN:		<input type="checkbox"/> Full SSN Reported			<input type="checkbox"/> Client doesn't know			<input type="checkbox"/> Approximate or partial SSN reported			<input type="checkbox"/> Client prefers not to answer			<input type="checkbox"/> Data not collected					
CLIENT NAME																			
Last:																			
First:																			
Middle										Suffix:									
QUALITY OF NAME		<input type="checkbox"/> Full name reported			<input type="checkbox"/> Client doesn't know			<input type="checkbox"/> Partial, street name or code name reported			<input type="checkbox"/> Client prefers not to answer			<input type="checkbox"/> Data not collected					
DATE OF BIRTH (DOB)				—						—									
		MONTH			DAY			YEAR											
QUALITY OF DOB		<input type="checkbox"/> Full DOB reported			<input type="checkbox"/> Client doesn't know			<input type="checkbox"/> Approximate or partial DOB reported			<input type="checkbox"/> Client prefers not to answer			<input type="checkbox"/> Data not collected					
GENDER (select all that apply)																			
<input type="checkbox"/> Woman (Girl if child)						<input type="checkbox"/> Non-binary						<input type="checkbox"/> Client doesn't know							
<input type="checkbox"/> Man (Boy if child)						<input type="checkbox"/> Questioning						<input type="checkbox"/> Client prefers not to answer							
<input type="checkbox"/> Culturally Specific Identity (e.g., Two Spirit)						<input type="checkbox"/> Different Identity						<input type="checkbox"/> Data not collected							
<input type="checkbox"/> Transgender																			
If different identity, please specify: _____																			
CLIENT PRONOUNS																			
<input type="checkbox"/> She/Her/Hers					<input type="checkbox"/> They/Them/Theirs					<input type="checkbox"/> Client prefers not to answer					<input type="checkbox"/> Other pronouns: _____				
<input type="checkbox"/> He/Him/His					<input type="checkbox"/> Client doesn't know					<input type="checkbox"/> Data not collected									
RACE/ETHNICITY (select all that apply)																			
<input type="checkbox"/> American Indian, Alaska Native, or Indigenous						<input type="checkbox"/> Hispanic/Latina/e/o						<input type="checkbox"/> Client doesn't know							
<input type="checkbox"/> Asian or Asian American						<input type="checkbox"/> Middle Eastern or North African						<input type="checkbox"/> Client prefers not to answer							
<input type="checkbox"/> Black, African American, or African						<input type="checkbox"/> Native Hawaiian or Pacific Islander						<input type="checkbox"/> Data not collected							
						<input type="checkbox"/> White													
Additional Race and Ethnicity Detail (optional): _____																			
RELATIONSHIP TO HEAD OF HOUSEHOLD																			
<input type="checkbox"/> Self (Head of Household)										<input type="checkbox"/> Head of household's other relation member									
<input type="checkbox"/> Head of Household's Child										<input type="checkbox"/> Other: nonrelation member									
<input type="checkbox"/> Head of Household's spouse or partner																			

PROJECT NAME										
PROJECT START DATE (mm/dd/yyyy)				—			—			

Disabling Condition

<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Yes	<input type="checkbox"/> Client prefers not to answer
	<input type="checkbox"/> Data not collected

Physical Disability

<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Yes*	<input type="checkbox"/> Client prefers not to answer
	<input type="checkbox"/> Data not collected

*If YES for Physical Disability Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Yes	<input type="checkbox"/> Client prefers not to answer
		<input type="checkbox"/> Data not collected

Developmental Disability

<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Yes	<input type="checkbox"/> Client prefers not to answer
	<input type="checkbox"/> Data not collected

Chronic Health Condition

<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Yes*	<input type="checkbox"/> Client prefers not to answer
	<input type="checkbox"/> Data not collected

*If YES for Chronic Health Condition Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Yes	<input type="checkbox"/> Client prefers not to answer
		<input type="checkbox"/> Data not collected

HIV/AIDS

<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Yes	<input type="checkbox"/> Client prefers not to answer
	<input type="checkbox"/> Data not collected

Mental Health Disorder

<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Yes*	<input type="checkbox"/> Client prefers not to answer
	<input type="checkbox"/> Data not collected

*If YES for Mental Health Disorder Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Yes	<input type="checkbox"/> Client prefers not to answer
		<input type="checkbox"/> Data not collected

Substance Use Disorder

<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Alcohol Use Disorder*	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Drug Use Disorder*	<input type="checkbox"/> Data not collected
<input type="checkbox"/> Both Alcohol and Drug Use Disorder*	

*If YES for Mental Health Disorder	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
	<input type="checkbox"/> Yes	<input type="checkbox"/> Client prefers not to answer

Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

Data not collected

HEALTH INSURANCE

Covered by health insurance?

No
 Yes*

Client doesn't know
 Client prefers not to answer
 Data not collected

***If YES to Covered by Health Insurance – Indicate all sources that apply**

- Medicaid
- Medicare
- State Children's Health Insurance Program
- Veteran's Health Administration (VHA)
- Employer-Provided Health Insurance

- Health Insurance Obtained Through COBRA
- Private Pay Health Insurance
- State Health Insurance for Adults
- Indian Health Services Program
- Other Health Insurance
(Specify source: _____)

Signature of parent/guardian stating all information is true and correct

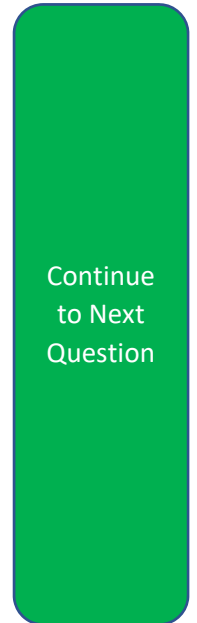
Date

Current Living Situation

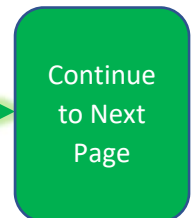
Date: ____/____/____

Select one

Homeless Situations	Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)	<input type="checkbox"/>
	Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter	<input type="checkbox"/>
	Safe Haven	<input type="checkbox"/>
Institutional Situations	Foster care home or foster care group home	<input type="checkbox"/>
	Hospital or other residential non-psychiatric medical facility	<input type="checkbox"/>
	Jail, prison or juvenile detention facility	<input type="checkbox"/>
	Long-term care facility or nursing home	<input type="checkbox"/>
	Psychiatric hospital or other psychiatric facility	<input type="checkbox"/>
	Substance abuse treatment facility or detox center	<input type="checkbox"/>
Temporary and Permanent Housing Situations	Residential project or halfway house with no homeless criteria	<input type="checkbox"/>
	Hotel or motel paid for without emergency shelter voucher	<input type="checkbox"/>
	Transitional housing for homeless persons (including homeless youth)	<input type="checkbox"/>
	Host Home (non-crisis)	<input type="checkbox"/>
	Staying or living in a friend's room, apartment or house	<input type="checkbox"/>
	Staying or living in a family member's room, apartment or house	<input type="checkbox"/>
	Rental by client, with GPD TIP housing subsidy	<input type="checkbox"/>
	Rental by client, with VASH housing subsidy	<input type="checkbox"/>
	Permanent housing (other than RRH) for formerly homeless persons	<input type="checkbox"/>
	Rental by client, with RRH or equivalent subsidy	<input type="checkbox"/>
	Rental by client, with HCV voucher (tenant or project based)	<input type="checkbox"/>
	Rental by client in a public housing unit	<input type="checkbox"/>
	Rental by client, no ongoing housing subsidy	<input type="checkbox"/>
	Rental by client, with other ongoing housing subsidy	<input type="checkbox"/>
	Owned by client, with ongoing housing subsidy	<input type="checkbox"/>
Owned by client, no ongoing housing subsidy	<input type="checkbox"/>	
Other	Other	<input type="checkbox"/>
	Worker unable to determine	<input type="checkbox"/>
	Client doesn't know	<input type="checkbox"/>
	Client refused	<input type="checkbox"/>
	Data not collected	<input type="checkbox"/>



Is client going to have to leave their current living situation within 14 days?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
	Client doesn't know	<input type="checkbox"/>
	Client refused	<input type="checkbox"/>
	Data not collected	<input type="checkbox"/>



Has a subsequent residence been identified?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
	Client doesn't know	<input type="checkbox"/>
	Client refused	<input type="checkbox"/>
	Data not collected	<input type="checkbox"/>

Does individual or family have resources or support networks to obtain other permanent housing?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
	Client doesn't know	<input type="checkbox"/>
	Client refused	<input type="checkbox"/>
	Data not collected	<input type="checkbox"/>

Has the client had a lease or ownership interest in a permanent housing unit in the last 60 days?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
	Client doesn't know	<input type="checkbox"/>
	Client refused	<input type="checkbox"/>
	Data not collected	<input type="checkbox"/>

Has the client moved 2 or more times in the last 60 days?	Yes	<input type="checkbox"/>
	No	<input type="checkbox"/>
	Client doesn't know	<input type="checkbox"/>
	Client refused	<input type="checkbox"/>
	Data not collected	<input type="checkbox"/>





Colorado Springs/ El Paso County Coordinated Assessment for Families

Every assessor in our community regardless of organization completing the VI-SPDAT should use an 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 should take less than 10 minutes to complete
- that only "Yes," "No," or one-word answers are being sought
- that any question can be skipped or prefers not to answer
- 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.

Example text:

Hi, I'm _____ and I work[volunteer] for _____. I would like to go through a short survey with you that will provide us with more information about your situation. The answers will help us determine how we can best support you. Some of the survey questions are personal in nature, but they only require a Yes, No, or one word answer. I really only need that one word answer. Please don't feel any pressure to provide more detail. There is no "right" or "wrong" answer and you don't need to conceal information because we can only help if we know your situation. We appreciate your honesty and understand if you want to skip or refuse a question. If you don't understand one of the questions I ask you, you can ask for clarification at any time. Please know the information collected will go into a data system which homeless community agencies access to coordinate the best services based on your information. If you don't provide us honest answers we might miss connecting you to opportunities that are most appropriate for you (and your family). Does this make sense or do you have any questions before we get started?

Interviewer's Name:

Agency:

Assessment Date:

Assessment Location:

Agency office

Outdoors

Assessment method:

Phone

In person

Virtual/online

Assessment Level: *(this will always be Housing needs assessment, not Crisis needs in our CoC)*

Primary Language: _____

NOTE: text in *BLUE ITALICS* is supplemental information to guide the interviewer and not part of the original VI-SPDAT, and should not be read aloud to the client unless they request clarification on a question. Please note that some questions say ANY person in the family, and others say EVERY person in the family-please be clear when reading the questions to the respondent.

VULNERABILITY INDEX SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL (VI-SPDAT)

Children

1. How many children under the age of 18 are currently with you?
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? *(this includes VOLUNTARY placement of children with family or friends, but not situations where DHS has revoked custody and will require a multiple step process before the client regains custody. A full intake form should be filled out for each child included)*
3. Is any member of the family currently pregnant? *(this reference to “family” includes any member of the household that is or expects to be housed together)*
4. Please provide a list of children's names and ages: *(it is important to remember three categories: under 6 years old, 6-12, and 13-17.)*

_____	_____
_____	_____
_____	_____

5. Where do you and your family sleep most frequently? *(Let the client answer in their own words, then check one. If the family is currently experiencing separate sleeping arrangements, have the respondent answer for themselves)*

- Shelters *(including domestic violence shelter or hotel paid by a charitable source)*
- Transitional Housing
- Safe Haven
- Outdoors *(including in a tent, abandoned building, etc.)*
- Couch Surfing *(note that adults that are couch surfing are typically not considered literally homeless)*
- Car *(including an RV or other vehicle if there is no running water)*
- Other (specify):
- Client doesn't know
- Client prefers not to answer

6. How long has it been since you and your family lived in permanent stable housing? *(if client needs clarification, had the right to receive mail at a place they lived together as a family for more than 90 days.)*

- | | |
|--|--|
| <input type="radio"/> Less than a week | <input type="radio"/> 1-2 years |
| <input type="radio"/> 1 week to 3 months | <input type="radio"/> 2 years or more |
| <input type="radio"/> 3-6 months | <input type="radio"/> Client doesn't know |
| <input type="radio"/> 6 months to one year | <input type="radio"/> Client prefers not to answer |

(For the next question, help the client pick a date six months ago, and tell them to answer the following)

Details for “How long...?”

- Less than 1 month
- 1 month
- 2 months
- 3 months
- 4 months
- 5 months
- 6 months
- 7 months
- 8 months
- 9 months
- 10 months
- 11 months
- 1 – 2 years
- 2 years or more
- Client doesn’t know
- Client prefers not to answer

In the last three years, how many times have you and your family been homeless?

- 0 times
- 1 time
- 2 times
- 3 times
- 4 times
- 5 or more times
- Client doesn’t know
- Client prefers not to answer

(For the next question, help the client pick a date six months ago, and tell them to answer the following.)

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

Received health care at an emergency room? <i>(including freestanding ER but NOT urgent care centers)</i>	
Been taken by an ambulance to the hospital? <i>(one point per patient, riding with a friend or family member who is receiving care does not count, but two patients in one ambulance would count as two points)</i>	
Been hospitalized as an inpatient? <i>(including “outpatient observation” status, if client needs clarification, we would include any time they stayed overnight in a bed somewhere other than the ER. This would also include hospitalization for mental health.)</i>	
Used a crisis service, including sexual assault crisis, mental health crisis, family or intimate violence, distress centers and suicide prevention hotlines? <i>(including phone, chat, or in person crisis centers)</i>	
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?	
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? <i>(note: this is number of events, not number of days)</i>	

9. Have you or anyone in your family been attacked or beaten up since they've become homeless? *(this is any period of homelessness, not just the past six months)*

- No
- Yes
- Client doesn’t know
- Client prefers not to answer

10. Have you or anyone in your family threatened to or tried to harm themselves or anyone else in the last year? *(the last 12 months regardless of if they were homeless or not at the time)*

- No
- Yes
- Client doesn’t know
- Client prefers not to answer

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? *(this could include civil or criminal legal issues. This does not include family/divorce court issues like custody or restraining orders, there is a separate question for that later)*

- No
- Yes
- Client doesn't know
- Client prefers not to answer

12. Does anybody force or trick you or anyone in your family to do things that you do not want to do?

- No
- Yes
- Client doesn't know
- Client prefers not to answer

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?

- No
- Yes
- Client doesn't know
- Client prefers not to answer

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? *(Client does not need to agree that they owe the money)*

- No
- Yes
- Client doesn't know
- Client prefers not to answer

15. Do you or anyone in your family get any money from the government, a pension, an inheritance, working *(regular recurring income, not a one time gift or occasional support from family)*

- No
- Yes
- Client doesn't know
- Client prefers not to answer

16. Does everyone in your family have planned activities, other than just surviving, that make them feel happy and fulfilled? *(this does not need to be the same thing for everybody)*

- No
- Yes
- Client doesn't know
- Client prefers not to answer

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? *(this refers to both the physical ability to do these things and access to the resources necessary, as developmentally appropriate.)*

- No
- Yes
- Client doesn't know
- Client prefers not to answer

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? *(remind client if necessary they do not need to tell us the details of the event. If it is within your scope of training to assist the client in processing social relationship issues, please wait until after the spdat is complete to do so)*

- No
- Yes
- Client doesn't know
- Client prefers not to answer

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? *(Clarification if needed: examples could include a mobility issue, mold or other environmental issues exacerbating health conditions, lack of electricity to run necessary medical equipment, etc)*

- No
- Yes
- Client doesn't know
- Client prefers not to answer

20. Do you or anyone in your family have any chronic health issues with your liver, kidneys, stomach, lungs or heart? *(these five body systems only)*

- No
- Yes
- Client doesn't know
- Client prefers not to answer

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? *(this should only be yes if someone in the household needs support with medical care for HIV)*

- No
- Yes
- Client doesn't know
- Client prefers not to answer

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? *(example: wheelchair access)*

- No
- Yes
- Client doesn't know
- Client prefers not to answer

23. When someone in your family is sick or not feeling well, does your family avoid getting medical help? *(this is for any reason, and we do not need the reason stated. Examples include lack of transportation, cost, distrust of medical system, etc)*

- No
- Yes
- Client doesn't know
- Client prefers not to answer

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? *(this could be financial or behavioral reasons)*

- No
- Yes
- Client doesn't know
- Client prefers not to answer

25. Will drinking or drug use make it difficult for your family to stay housed or afford your housing?

- No
- Yes
- Client doesn't know
- Client prefers not to answer

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: *(question should be answered on its own merit, not dependent on the responses from other parts of the question. One issue in particular could prompt a "yes" response to more than one section of this question)*

a) A mental health issue or concern?

- No
- Yes
- Client doesn't know
- Client prefers not to answer

b) A past head injury?

- No
- Yes
- Client doesn't know
- Client prefers not to answer

c) A learning disability, developmental disability, or other impairment?

- No
- Yes
- Client doesn't know
- Client prefers not to answer

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? *(example: forgetting to pay bills, debilitating anxiety about conflict with neighbors or landlord)*

- No
- Yes
- Client doesn't know
- Client prefers not to answer

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?

- No
- Yes
- Client doesn't know
- Client prefers not to answer

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? *(this could include but is not limited to reasons like cannot afford the medication, don't like the side effects, or don't agree the medication is necessary)*

- No
- Yes
- Client doesn't know
- Client prefers not to answer

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? *(this could include taking more OR less than prescribed)*

- No
- Yes
- Client doesn't know
- Client prefers not to answer

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?

- No
- Yes
- Client doesn't know
- Client prefers not to answer

32. Are there any children that have been removed from the family by a child protection service within the last 180 days? *(use the same 6 month benchmark as the first set of questions about the last six months)*

- No
- Yes
- Client doesn't know
- Client prefers not to answer

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? *(example: custody agreements or restraining orders)*

- No
- Yes
- Client doesn't know
- Client prefers not to answer

34. In the last 180 days have any children lived with family or friends because of your homelessness or housing situation? *(this is for voluntary placement, removal by CPS is covered in question 32.)*

- No
- Yes
- Client doesn't know
- Client prefers not to answer

35. Has any child in the family experienced abuse or trauma in the last 180 days? *(example: child bullied at school or lost an extremely important item during an eviction)*

- No
- Yes
- Client doesn't know
- Client prefers not to answer

36. IF THERE ARE SCHOOL-AGED CHILDREN: Do your children attend school more often than not each week? *(assuming school is in session: during school holidays, you can preface this question with "when school is in session")*

- No
- Yes
- Client doesn't know
- Client prefers not to answer

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? *(reminder: we do not need details of how the family has changed. By Family, we mean the members of the household that are living together as a family unit)*

- No
- Yes
- Client doesn't know
- Client prefers not to answer

38. Do you anticipate any other adults or children coming to live with you within the first 180 days of being housed? *(If yes, strongly consider if that person needs to be on the initial CE enrollment. We want to make sure that the housing we find is sufficiently sized for the household. If you cannot add to the initial enrollment, such as an unborn baby, please note in the referral that the household size will change)*

- No
- Yes
- Client doesn't know
- Client prefers not to answer

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? *(this is time spent together as a family unit, not individual activities)*

- No
- Yes
- Client doesn't know
- Client prefers not to answer

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 *(responsible adult: a person over 18 who would be capable of handling an emergency such as an injury requiring medical attention)*

- a) 3 or more hours per day for children aged 13 or older?

- No
- Yes
- Client doesn't know
- Client prefers not to answer

b) 2 or more hours per day for children aged 12 or younger?

- No
- Yes
- Client doesn't know
- Client prefers not to answer

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? *(note that this says typical day, indicating a regular responsibility/chore, not an occasional babysitting situation among siblings)*

- No
- Yes
- Client doesn't know
- Client prefers not to answer

Post VI-SPDAT questions:

On a regular day, where is it easiest to find you and what time of day is easiest to do so? [\(Enter this information on the Contact tab in HMIS\)](#)

Is there a phone number and /or email where someone can safely get in touch with you or leave you a message? [\(Enter this information on the Contact tab in HMIS\)](#)

Number/Email: _____

Contact type:

- Direct client contact
- Messages only

This form was adapted from the Service Prioritization Decision Assistance Tool-Prescreen Triage Tool for Families

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