

Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT)

Prescreen for Single Adults

GENERAL INFORMATION/CONSENT

Interviewer's Name		Agency <input type="checkbox"/> TEAM <input type="checkbox"/> STAFF <input type="checkbox"/> VOLUNTEER	
Date	Time	Location	
In what language do you feel best able to express yourself?			
First Name		Last Name	
Nickname		Social Security Number	
How old are you?	What's your date of birth?	Has Consented to Participate <input type="checkbox"/> YES <input type="checkbox"/> NO	
If 60 years or older, then score 1.			Prescreen Score
PRE-SCREEN GENERAL INFORMATION SUBTOTAL			

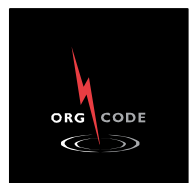
A. HISTORY OF HOUSING & HOMELESSNESS

QUESTIONS			
If the person has experienced two or more cumulative years of homelessness, and/or 4+ episodes of homelessness, then score 1.	RESPONSE	REFUSED	Prescreen Score
1. What is the total length of time you have lived on the streets or in shelters?		<input type="checkbox"/>	
2. In the past three years, how many times have you been housed and then homeless again?		<input type="checkbox"/>	
PRE-SCREEN HOUSING AND HOMELESSNESS SUBTOTAL			

100,000 HOMES

For 100,000 homeless individuals and families

POWERED BY COMMUNITY SOLUTIONS



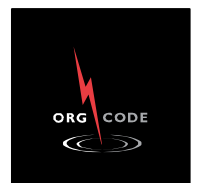
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B. RISKS

SCRIPT: I am going to ask you some questions about your interactions with health and emergency services. If you need any help figuring out when six months ago was, just let me know.

QUESTIONS				RESPONSE	REFUSED	Prescreen Score
If the total number of interactions across questions 3, 4, 5, 6 and 7 is equal to or greater than 4, then score 1.						
3. In the past six months, how many times have you been to the emergency department/room?					<input type="checkbox"/>	
4. In the past six months, how many times have you had an interaction with the police?					<input type="checkbox"/>	
5. In the past six months, how many times have you been taken to the hospital in an ambulance?					<input type="checkbox"/>	
6. In the past six months, how many times have you used a crisis service, including distress centers or suicide prevention hotlines?					<input type="checkbox"/>	
7. In the past six months, how many times have you been hospitalized as an in-patient, including hospitalizations in a mental health hospital?					<input type="checkbox"/>	
If YES to questions 8 or 9, then score 1.				YES	NO	REFUSED
8. Have you been attacked or beaten up since becoming homeless?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Threatened to or tried to harm yourself or anyone else in the last year?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If YES to question 10, then score 1.				YES	NO	REFUSED
10. Do you have any legal stuff going on right now that may result in you being locked up or having to pay fines?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If YES to questions 11 or 12; OR if respondent provides any answer <i>OTHER THAN</i> "Shelter" in question 13, then score 1.				YES	NO	REFUSED
11. Does anybody force or trick you to do things that you do not want to do?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. 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 really know, share a needle, or anything like that?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I am going to read types of places people sleep. Please tell me which one that you sleep at most often. (Check only one.)				<input type="checkbox"/> Shelter <input type="checkbox"/> Street, Sidewalk or Doorway <input type="checkbox"/> Car, Van or RV <input type="checkbox"/> Bus or Subway <input type="checkbox"/> Beach, Riverbed or Park <input type="checkbox"/> Other (SPECIFY):		
PRE-SCREEN RISKS SUBTOTAL						

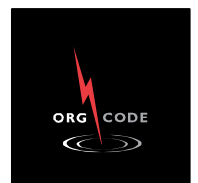


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C. SOCIALIZATION & DAILY FUNCTIONS

QUESTIONS				
	YES	NO	REFUSED	Prescreen Score
If YES to question 14 or NO to questions 15 or 16, score 1.				
14. Is there anybody that thinks you owe them money?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15. Do you have any money coming in on a regular basis, like a job or government benefit or even working under the table, binning or bottle collecting, sex work, odd jobs, day labor, or anything like that?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16. Do you have enough money to meet all of your expenses on a monthly basis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If NO to question 17, score 1.				
17. Do you have planned activities each day other than just surviving that bring you happiness and fulfillment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If YES to questions 18 or 19, score 1.				
18. Do you have any friends, family or other people in your life out of convenience or necessity, but you do not like their company?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19. Do any friends, family or other people in your life ever take your money, borrow cigarettes, use your drugs, drink your alcohol, or get you to do things you really don't want to do?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
OBSERVE ONLY. DO NOT ASK! If YES, score 1.				
20. Surveyor, do you detect signs of poor hygiene or daily living skills?	<input type="checkbox"/>	<input type="checkbox"/>		
PRE-SCREEN SOCIALIZATION & DAILY FUNCTIONS SUBTOTAL				



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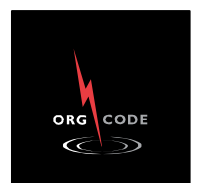
D. WELLNESS

QUESTIONS				
If Does Not Go For Care, score 1.		RESPONSE		Prescreen Score
21. Where do you usually go for healthcare or when you're not feeling well?		<input type="checkbox"/> Hospital <input type="checkbox"/> Clinic <input type="checkbox"/> VA <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Does not go for care		
For EACH YES response in questions 22 through 25 (Medical Conditions), score 1.				
Do you have now, have you ever had, or has a healthcare provider ever told you that you have any of the following medical conditions:	YES	NO	REFUSED	Medical Conditions
22. Kidney disease/End Stage Renal Disease or Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
23. History of frostbite, Hypothermia, or Immersion Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
24. Liver disease, Cirrhosis, or End-Stage Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
25. HIV+/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If YES to any of the conditions in questions 26 to 34, then mark "X" in Other Medical Condition column.	YES	NO	REFUSED	Other Medical Conditions
26. History of Heat Stroke/Heat Exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
27. Heart disease, Arrhythmia, or Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
28. Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
29. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
30. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
31. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32. Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
33. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
OBSERVATION ONLY – DO NOT ASK:	<input type="checkbox"/>	<input type="checkbox"/>		
34. Surveyor, do you observe signs or symptoms of a serious health condition?	<input type="checkbox"/>	<input type="checkbox"/>		
If any response is YES in questions 35 through 41, score 1 in the Substance Use column.	YES	NO	REFUSED	Substance Use
35. Have you ever had problematic drug or alcohol use, abused drugs or alcohol, or told you do?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
36. Have you consumed alcohol and/or drugs almost every day or every day for the past month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
37. Have you ever used injection drugs or shots in the last six months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
38. Have you ever been treated for drug or alcohol problems and returned to drinking or using drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
39. Have you used non-beverage alcohol like cough syrup, mouthwash, rubbing alcohol, cooking wine, or anything like that in the past six months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
40. Have you blacked out because of your alcohol or drug use in the past month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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OBSERVATION ONLY – DO NOT ASK: 41. Surveyor, do you observe signs or symptoms or problematic alcohol or drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>		
If any response is YES in questions 42 through 48, score 1 in the Mental Health Column.	YES	NO	REFUSED	Mental Health
42. Ever been taken to a hospital against your will for a mental health reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
43. Gone to the emergency room because you weren't feeling 100% well emotionally or because of your nerves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
44. Spoken with a psychiatrist, psychologist or other mental health professional in the last six months because of your mental health – whether that was voluntary or because someone insisted that you do so?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
45. Had a serious brain injury or head trauma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
46. Ever been told you have a learning disability or developmental disability?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
47. Do you have any problems concentrating and/or remembering things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
OBSERVATION ONLY – DO NOT ASK: 48. Surveyor, do you detect signs or symptoms of severe, persistent mental illness or severely compromised cognitive functioning?	<input type="checkbox"/>	<input type="checkbox"/>		
If the Substance Use score is 1 AND the Mental Health score is 1 AND the Medical Condition score is at least a 1 OR an X, then score 1 additional point for tri-morbidity.				Tri-Morbidity
If YES to question 49, score 1.	YES	NO	REFUSED	Prescreen Score
49. Have you had any medicines prescribed to you by a doctor that you do not take, sell, had stolen, misplaced, or where the prescriptions were never filled?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If YES to question 50, score 1.	YES	NO	REFUSED	Prescreen Score
50. Yes or No – Have you experienced any emotional, physical, psychological, sexual or other type of abuse or trauma in your life which you have not sought help for, and/or which has caused your homelessness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PRE-SCREEN WELLNESS SUBTOTAL				

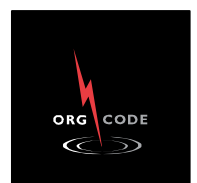
SCORING SUMMARY

DOMAIN	SUBTOTAL	
GENERAL INFORMATION		If the Pre-Screen Total is equal to or greater than 10, the individual is recommended for a Permanent Supportive Housing/Housing First Assessment. If the Pre-Screen Total is 5, 6, 7, 8 or 9, the individual is recommended for a Rapid Re-Housing Assessment. If the Pre-Screen Total is 0, 1, 2, 3 or 4, the individual is not recommended for a Housing and Support Assessment at this time.
A. HISTORY OF HOUSING AND HOMELESSNESS		
B. RISKS		
C. SOCIALIZATION AND DAILY FUNCTIONS		
D. WELLNESS		
PRE-SCREEN TOTAL		

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Finally I'd like to ask you some questions to help us better understand homelessness and improve housing and support services.

What is your gender?	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Other <input type="checkbox"/> Decline to State
Have you ever served in the US Military?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
<i>If yes, which war/war era did you serve in?</i>	<input type="checkbox"/> Korean War (June 1950-January 1955) <input type="checkbox"/> Vietnam Era (August 1964-April 1975) <input type="checkbox"/> Post Vietnam (May 1975-July 1991) <input type="checkbox"/> Persian Gulf Era (August 1991-Present) <input type="checkbox"/> Afghanistan (2001-Present) <input type="checkbox"/> Iraq (2003-Present) <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Refused
<i>If yes, what was the character of your discharge?</i>	<input type="checkbox"/> Honorable <input type="checkbox"/> Other than Honorable <input type="checkbox"/> Bad Conduct <input type="checkbox"/> Dishonorable <input type="checkbox"/> Refused
What is your citizenship status?	<input type="checkbox"/> Citizen <input type="checkbox"/> Legal Resident <input type="checkbox"/> Undocumented <input type="checkbox"/> Refused
Where did you live prior to becoming homeless?	<input type="checkbox"/> This city <input type="checkbox"/> This region <input type="checkbox"/> Other part of the State <input type="checkbox"/> Somewhere else (specify) _____
Have you ever been in foster care?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
Have you ever been in jail?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
Have you ever been in prison?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
Do you have a permanent physical disability that limits your mobility? [i.e., wheelchair, amputation, unable to climb stairs]?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
What kind of health insurance do you have, if any? (check all that apply)	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> VA <input type="checkbox"/> Private Insurance <input type="checkbox"/> None <input type="checkbox"/> Other (specify): _____
On a regular day, where is it easiest to find you and what time of day is easiest to do so?	
Is there a phone number and/or email where someone can get in touch with you or leave you a message?	
Ok, now I'd like to take your picture. May I do so?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused

