

VT HMIS BoS CE – At Risk and Literally Homeless Status Form

HMIS Client ID: _____

Project Status Date: _____

Client Contact Information:

Email Address: _____

Phone (#1) _____ Phone (#2) _____

Contact Date _____

Note: *With client permission, this would be a place to add emergency contact, alternative contact, mailing address, etc.*

Client Status: *Status Update and Assessments are located within the program enrollment*

Does client have someone providing housing navigation support / case management? Yes No

Name of Housing Navigator / Case Manager: _____

Living Situation at time of Assessment: *Answer for all household members (Adults and Children)*

Type of Residence:

----- HOMELESS SITUATIONS -----
<input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher, Host Home
<input type="checkbox"/> Place not meant for habitation
----- INSTITUTIONAL SITUATIONS -----
<input type="checkbox"/> 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
--- TEMPORARY 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 with family (temporary) room, apartment, or house
<input type="checkbox"/> Staying or living with friends (temporary) room, apartment, or house
--- PERMANENT HOUSING SITUATIONS ---
<input type="checkbox"/> Staying or living with family (permanent)
<input type="checkbox"/> Staying or living with friends (permanent)
<input type="checkbox"/> Rental by client, no ongoing housing subsidy
<input type="checkbox"/> Rental by client, with ongoing housing subsidy <i>(if selected, answer 'Rental Subsidy Type' below)</i>
<input type="checkbox"/> Owned by client, with ongoing housing subsidy
<input type="checkbox"/> Owned by client, no ongoing housing subsidy

Rental Subsidy Type: *Answer if 'Rental by client, with ongoing housing subsidy' is selected.*

<input type="checkbox"/> GPD TIP housing subsidy
<input type="checkbox"/> VASH housing subsidy

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<input type="checkbox"/> RRH or equivalent subsidy
<input type="checkbox"/> HCV voucher (tenant or project based) (not dedicated)
<input type="checkbox"/> Public housing unit
<input type="checkbox"/> Rental by client, with other ongoing housing subsidy
<input type="checkbox"/> Housing Stability Voucher
<input type="checkbox"/> Family Unification Program Voucher (FUP)
<input type="checkbox"/> Foster Youth to Independence Initiative (FYI)
<input type="checkbox"/> Permanent Supportive Housing
<input type="checkbox"/> Other permanent housing dedicated for formerly homeless persons

Length of Stay in Prior Living Situation:

<input type="checkbox"/> One day or less	<input type="checkbox"/> One month or more, but less than 90 days
<input type="checkbox"/> Two Day to six nights	<input type="checkbox"/> 90 days or more, but then than one year
<input type="checkbox"/> One week or more, but less than one month	<input type="checkbox"/> One year or longer

Approximate Date This Episode of Homelessness Started: _____

Number of times on the streets, in ES, or Safe Haven in the past three years:

<input type="checkbox"/> One time	<input type="checkbox"/> Two times	<input type="checkbox"/> Three times	<input type="checkbox"/> Four or more times
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Total number of months homeless on the streets, in ES, or Safe Haven in the past 3 years:

<input type="checkbox"/> One month (This is first month)	<input type="checkbox"/> 4	<input type="checkbox"/> 7	<input type="checkbox"/> 10
<input type="checkbox"/> 2	<input type="checkbox"/> 5	<input type="checkbox"/> 8	<input type="checkbox"/> 11
<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9	<input type="checkbox"/> 12
			<input type="checkbox"/> More than 12 months

Total number of months spent homeless in lifetime:

<input type="checkbox"/> Less than 1 year	<input type="checkbox"/> 12 – 60 months (2 – 5 years)
<input type="checkbox"/> 12 – 23 months	<input type="checkbox"/> More than 60 months (5+ years)

Disabling Conditions and Barriers: *Answer for all household members (Adults and Children)*

Does the client have a disabling condition? Yes No

Disability Type	Disability Determination	If Yes, long term?
Alcohol Use Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Both Alcohol and Drug Use Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Use Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Developmental Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	Automatically considered long term
Mental Health Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Automatically considered long term

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Do you currently receive services or treatment for the disabling conditions identified? Yes No

Do you or anyone in your household have any urgent medical conditions right now that you need help with?

Yes No

Do you or anyone in your household need help finding a primary care doctor? Yes No

Survivor of Domestic Violence: *Answer for all Adults in household (18 years older)*

Yes No

If Yes for domestic violence survivor, when experience occurred:

<input type="checkbox"/> Within the past three months	<input type="checkbox"/> From six to twelve months ago
<input type="checkbox"/> Three to six months ago	<input type="checkbox"/> More than a year

If Yes for domestic violence survivor, are you currently fleeing? Yes No

Monthly Income: *Answer for HoH and all Adults in household (18 years older)*

Income from Any Source: Yes No

Total Monthly Income: _____

Source of Income	Receiving Income Source?		Monthly Amount
Alimony or Other Spousal Support	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Child Support	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Earned Income	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
General Assistance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Pension or retirement income from another job	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Private Disability Insurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Retirement Income from Social Security	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
SSDI	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
SSI	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
TANF – (VT Reach Up)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Unemployment Insurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
VA Non-Service Connected Disability Pension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
VA Service Connected Disability Compensation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Workers Compensation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$

Is the household income at or below 50% AMI? Yes No

Non-Cash Benefits: *Answer for HoH and all Adults in household (18 years older)*

Non-cash benefits from any source: Yes No

Source of Income	Receiving Income Source?	
Supplemental Nutrition Assistance Program (Food Stamps)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Special Supplemental nutrition Program for WIC	<input type="checkbox"/> Yes	<input type="checkbox"/> No
TANF Child Services	<input type="checkbox"/> Yes	<input type="checkbox"/> No
TANF Transportation Services	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other TANF-Funded Services	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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Other Source	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Health Insurance: *Answer for all household members (Adults and Children)*

Covered by Health Insurance: Yes No

Source of Income	Receiving Income Source?	
MEDICAID	<input type="checkbox"/> Yes	<input type="checkbox"/> No
MEDICARE	<input type="checkbox"/> Yes	<input type="checkbox"/> No
State Children’s Health Insurance Program	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Veteran’s Health Administration (VHA)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Employer – Provided Health Insurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Health Insurance obtained through Cobra	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Private Pay Health Insurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No
State Health Insurance for Adults	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Indian Health Services Program	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Service Connections:

Are you currently on Probation or Parole? Yes No

If yes, Parole Officer’s Name? _____ Parole Officer’s Phone Number: _____

Type of Offense? _____

How many bedrooms needed in a future rental? _____

Do any of these soft referrals need to be made? *Select all that apply*

<input type="checkbox"/> Emergency shelter/housing – 211 for local shelter, ESD for GA Emergency Housing
<input type="checkbox"/> Homeownership Center
<input type="checkbox"/> CVOEO Mobile Home Project
<input type="checkbox"/> Homeless Education Liaisons
<input type="checkbox"/> Employment, training, or education opportunities – for people with disability: Hire Ability VT
<input type="checkbox"/> Employment, training, or education opportunities – for all other, VT Department of Labor
<input type="checkbox"/> Veteran Services/Veteran CE Referral
<input type="checkbox"/> Public Benefit Programs
<input type="checkbox"/> Support for adults to complete high school / GED
<input type="checkbox"/> Domestic/sexual violence advocate for support
<input type="checkbox"/> Substance Use services or treatment
<input type="checkbox"/> Health Care Access

What do you have that will help you success with your housing plan? *Select all that apply*

<input type="checkbox"/> I have rental assistance or a housing voucher
<input type="checkbox"/> I have stable income
<input type="checkbox"/> I have landlord references

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<input type="checkbox"/> I have supportive friends or family
<input type="checkbox"/> I have someone who helps me advocate for my needs
<input type="checkbox"/> I have access to land
<input type="checkbox"/> I have a case manager or someone who is helping me with my housing plan
<input type="checkbox"/> I have my own determination and know-how!
<input type="checkbox"/> I have a job, or I am in a job training program

Current Living Situation: *Located on the Assessments tab within a program enrollment. Required for Coordinated Entry, PATH-enrolled clients, and other projects for Head of Household*

Date of Contact: _____

Current Living Situation:

----- HOMELESS SITUTAIONS -----
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<input type="checkbox"/> Rental by client, with ongoing housing subsidy <i>(if selected, answer 'Rental Subsidy Type' below)</i>
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Rental Subsidy Type: *Answer if 'Rental by client, with ongoing housing subsidy' is selected.*

<input type="checkbox"/> GPD TIP housing subsidy
<input type="checkbox"/> VASH housing subsidy
<input type="checkbox"/> RRH or equivalent subsidy
<input type="checkbox"/> HCV voucher (tenant or project based) (not dedicated)
<input type="checkbox"/> Public housing unit

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<input type="checkbox"/> Rental by client, with other ongoing housing subsidy
<input type="checkbox"/> Housing Stability Voucher
<input type="checkbox"/> Family Unification Program Voucher (FUP)
<input type="checkbox"/> Foster Youth to Independence Initiative (FYI)
<input type="checkbox"/> Permanent Supportive Housing
<input type="checkbox"/> Other permanent housing dedicated for formerly homeless persons

Is Client going to have to leave their current living situation within 14 days? *This field will populate if the client is coming from an institutional, temporary, or permanent housing situation*

Yes No

If 'Yes' to 'Is Client going to have to leave their current living situation within 14 days?' answer the following questions:

Has subsequent residence been identified?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the individual or family have resources or support networks to obtain other permanent housing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the client had a lease or ownership interest in a permanent housing unit in the last 60 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the client moved 2 or more times in the last 60 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Living Situation Verified by: *This field will populate for Coordinated Entry. Select appropriate program type and project*

Location Details: *Optional note section to put in specific details about location of client. Most helpful when unsheltered*

VT 2025 BoS Complex Service Needs At Risk and Literally Homeless Assessment: *Located on the Assessments tab within a program enrollment. Must be completed on the HoH client enrollment and referral to Community Queue must be sent for clients to prioritize on the BoS prioritization report.*

Assessment Date:			
Assessment Location:			
Assessment Type:	<input type="checkbox"/> Phone	<input type="checkbox"/> Virtual	<input type="checkbox"/> In Person
Assessment Level:	Housing Needs Assessment		

Complexity of Situation: *This section is located on the VT BoS CoC Housing Assessment and must be completed to calculate if the client's situation is complex or non-complex.*

A. Have you or a member of your household and For adults and Head of Household Only: *This section is located on the VT BoS CoC Housing Assessment and must be completed to calculate a client's place on the prioritization report.*

B. For Adults and Heads of Households Only: *This section is located on the VT BoS CoC Housing Assessment and must be completed to calculate a client's place on the prioritization report.*

C. Staff Member Answer from Information Collected Earlier: *The following questions must be answered for all adult members of the household in order for the household to be placed on the prioritization report correctly.*

Any adult in the household currently unsheltered or living in a place unfit for human habitation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any adult in the household have a history of unsheltered homelessness (not including current)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any adult survivor of domestic violence / sexual violence?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any adult household member living with a chronic medical condition that is disabling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

C. Information Collected Earlier: *This section pre-populates based on the HoH enrollment. If an adult member of the household (and included in the enrollment) has more months spent homeless than that of the HoH, please update accordingly.*

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<input type="checkbox"/> Less than 1 year	<input type="checkbox"/> 12 – 60 months (2 – 5 years)
<input type="checkbox"/> 12 – 23 months	<input type="checkbox"/> More than 60 months (5+ years)