

Referral Completed by: \_\_\_\_\_ Date/Time: \_\_\_\_\_

**PRE-SCREENING INFORMATION FOR SHELTER REFERRAL**

1. First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
 Other names (including nicknames): \_\_\_\_\_

2. Has client previously completed an application for assistance through Coordinated Entry?  Yes  No  Don't Know

3. Have you experienced domestic violence within the past 30 days?  Yes  No  Don't Know

If client acknowledges experiencing domestic violence within the last 30 days **STOP HERE**. Client should be provided with **24 HR Hotline Equinox (518) 432-7865**

4. Date of Birth MM/DD/YYYY \_\_\_\_\_ 5. How old are you? \_\_\_\_\_ 6. Social Security Number \_\_\_\_\_ 7. Primary Contact Number: \_\_\_\_\_  
 Emergency Contact Info: \_\_\_\_\_

If client acknowledges in **Question 4 & 5** that they are under the age of 18 (17 and under) **STOP HERE**. Client should be provided with the number and address below:  
**Equinox Youth Division (518) 465-9524 OR Safehouse, Inc. (518) 374-5178 OR Community Maternity Services (518) 482-8836** (for families under 24 years of age)

8. Where did you sleep last night? **Briefly explain:** \_\_\_\_\_

9. List the last 2 permanent address → → → → →	Address	County	Zip Code	Length of Stay	Reason for Move

10. Gender  Male  Female  Transgender Male to Female  Transgender Female to Male  Other  Don't Know

11. Have you been **diagnosed** with a mental illness?  Yes  No If Yes, Diagnosis: \_\_\_\_\_

12. Are you actively using illegal drugs or struggling with an addiction to alcohol?  Yes  No

13. Do you need help with daily tasks like showering, eating, etc.?  Yes  No **13a.** Are you physically disabled?  Yes  No  
 If so, please explain: \_\_\_\_\_

14. Can you walk upstairs?  Yes  No **15.** Can you sleep on the top bunk?  Yes  No **16.** Are you on any medications?  Yes  No

**HOUSEHOLD COMPOSITION/INCOME**

*Information on individuals who will live with the head of household.*

Full Name	Relationship to head/household	DOB	Age	Sources of income* (Wages, SSI, AFDC, etc.)	Monthly Income Amount	Documented disabling condition
1.						<input type="checkbox"/> Yes <input type="checkbox"/> No
2.						<input type="checkbox"/> Yes <input type="checkbox"/> No
3.						<input type="checkbox"/> Yes <input type="checkbox"/> No
4.						<input type="checkbox"/> Yes <input type="checkbox"/> No
5.						<input type="checkbox"/> Yes <input type="checkbox"/> No

**HOMELESS STATUS & CRIMINAL HISTORY**

17. Have you been living in a place not meant for human habitation or in an emergency shelter continuously for at least 1 year?  Yes  No  Don't Know

18. Were you homeless on at least 4 separate occasions in the last 3 years where the combined length of time homeless on those occasions equals 12 months or more?  Yes  No  Don't Know

19. How many months have you been homeless (this time)? \_\_\_\_\_

20. **Homeless Cause** (or reason seeking services if not currently homeless) If Known:  
 Benefits loss/reduction  Relocation  Release from prison/jail  Release from hospital  Release psychiatric facility  Injury  
 Asked to leave shared residence (e.g. living in a home of another)  Illness  Drug/alcohol abuse  Natural disaster  
 Job income loss/reduction  Domestic Violence  Eviction  Other: \_\_\_\_\_

21. **Have you been convicted of any of the following:**  
 Arson  Murder  Robbery  Assault  Sexual offense (level \_\_\_\_\_)  N/A  Don't Know **Other convictions:** \_\_\_\_\_

**MILITARY INFORMATION**

22. Have you served one active day in the military?  Yes  No **22a.** What was your branch of service and dates of service? \_\_\_\_\_

I understand that the information on this form may be shared with agencies funded through the Albany County Continuum of Care (CoC) and agency recipients of the Emergency Solutions Grant (ESG).

Signature of Head of Household \_\_\_\_\_ Date: \_\_\_\_\_

**HEAD of HOUSEHOLD HMIS DATA ELEMENTS**

<p><b>23. Race:</b></p> <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Don't Know <input type="checkbox"/> Asian <input type="checkbox"/> Refused <input type="checkbox"/> Black or African American	<p><b>24. Ethnicity</b></p> <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Don't Know	<p><b>25. Can person easily provide the following:</b></p> <table style="width:100%;"> <tr> <td>Social Security Card</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Birth Certificate</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Driver's License or Non-Driver ID</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No Picture</td> </tr> <tr> <td>Passport</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Alien Registration</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> </table>	Social Security Card	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Birth Certificate	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Driver's License or Non-Driver ID	<input type="checkbox"/> Yes	<input type="checkbox"/> No Picture	Passport	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Alien Registration	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Passport	<input type="checkbox"/> Yes	<input type="checkbox"/> No															
Alien Registration	<input type="checkbox"/> Yes	<input type="checkbox"/> No															

**HEAD of HOUSEHOLD INCOME & EMPLOYMENT**

**26.** Are you currently employed?       Yes     No  
 If **Yes**, where are you currently employed? \_\_\_\_\_ Hours Per Week: \_\_\_\_\_

**27. Sources of Income for Head of Household:**

\$ _____ Earned Income (i.e. employment)	\$ _____ Veteran's pension	\$ _____ Retirement income from SSA
\$ _____ SSI	\$ _____ Child Support	\$ _____ Pension from a former job
\$ _____ Veteran's Disability Payment	\$ _____ Unemployment benefits	\$ _____ Alimony or other spousal support
\$ _____ SSDI	\$ _____ Private Disability Insurance	\$ _____ Other
\$ _____ General Public Assistance	\$ _____ TANF	

**TOTAL INCOME FOR HEAD of HOUSEHOLD \$ \_\_\_\_\_**

**28. Sources of Non-Cash Benefits for Head of Household:**

<input type="checkbox"/> Food stamps	<input type="checkbox"/> MEDICAID health insurance program
<input type="checkbox"/> MEDICARE	<input type="checkbox"/> State Children's Health Insurance Program
<input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	<input type="checkbox"/> Veteran's Administration (VA) Medical Services
<input type="checkbox"/> TANF Child Care services	<input type="checkbox"/> TANF Transportation service
<input type="checkbox"/> Other TANF Funded services	<input type="checkbox"/> Section 8, public housing, or other ongoing rental assistance
<input type="checkbox"/> Temporary Rental Assistance	<input type="checkbox"/> Other source

**HOUSEHOLD CRIMINAL/ PROTECTIVE HISTORY**

**29.** Have you or any member of the household ever been convicted for a crime?  
 Yes     No     Don't Know     Refused  
 If **Yes**, briefly explain when, where and the nature of the crime. **Note:** Response should include illegal drug type if checked and/or status and level should be indicated if sexual offense is checked.  
 \_\_\_\_\_  
 \_\_\_\_\_

**29a.** If answered **Yes, to Question 29**, please explain if there are any legal restrictions?       N/A

**30.** Currently are you or any member of the household on Probation or Parole?       Yes     No     Don't Know  
 List household members on Probation/Parole:

If **Yes**, list the contact information for the Probation/Parole officer: **Name:** \_\_\_\_\_ **Contact Number:** (    ) \_\_\_\_\_ - \_\_\_\_\_

**31.** Do you have an order of protection against you?       Yes     No     Don't Know

**32.** Do you have an order of protection against someone?       Yes     No     Don't Know

**33.** If answered **Yes, to Question 31 or Question 32**, please list who and the relationship:

<table style="width:100%;"> <tr> <td style="text-align: center;"><u>Person (1)</u></td> <td style="text-align: center;"><u>Relationship to You</u></td> </tr> <tr> <td style="height: 40px;"></td> <td></td> </tr> </table>	<u>Person (1)</u>	<u>Relationship to You</u>			<table style="width:100%;"> <tr> <td style="text-align: center;"><u>Person(2)</u></td> <td style="text-align: center;"><u>Relationship to You</u></td> </tr> <tr> <td style="height: 40px;"></td> <td></td> </tr> </table>	<u>Person(2)</u>	<u>Relationship to You</u>		
<u>Person (1)</u>	<u>Relationship to You</u>								
<u>Person(2)</u>	<u>Relationship to You</u>								

**34.** Have you or any member of the household been involved with any protective agency?       Yes     No

**35. If Yes, to Question 34** please indicate which agency:     CPS     APS     Juvenile Justice     Family Court     Foster Care     Other \_\_\_\_\_

**35a.** If any of the above are checked, is this a current case?     Yes     No    **If No, date case was closed:** \_\_\_\_\_

Protective Agency Worker's **Name:** \_\_\_\_\_ **Contact Number:** (    ) \_\_\_\_\_ - \_\_\_\_\_

**HOUSEHOLD HEALTH CONDITIONS**

**36.** Do you have health insurance?     Yes     No

If yes, insurance provider: \_\_\_\_\_

**37.** Are you pregnant?

Yes     No     Don't Know     Refused    **If yes, due date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**INDICIATE ALL DISABILITY INFORMATION**

Below include information on head of household and all other individuals who will live in the household.

Disabling Condition	Diagnosis	Diagnosis Documented?	Would like treatment (Optional)	DIAGNOSIS (If applicable)	Household Member with Diagnosis (i.e. self, son, husband, etc.)
Physical illness/disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Mental Health Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chronic illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Alcohol Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**REFERRAL FOR SERVICES**

Please indicate which agencies this referral will be sent to:

**Referral 1: Agency:** \_\_\_\_\_ **Program:** \_\_\_\_\_

**Notes:** \_\_\_\_\_

**Referral 2: Agency:** \_\_\_\_\_ **Program:** \_\_\_\_\_

**Notes:** \_\_\_\_\_

**Referral 3: Agency:** \_\_\_\_\_ **Program:** \_\_\_\_\_

**Notes:** \_\_\_\_\_

**Referral 4: Agency:** \_\_\_\_\_ **Program:** \_\_\_\_\_

**Notes:** \_\_\_\_\_

## VULNERABILITY INDEX SCORING FOR INDIVIDUALS

### **Chronic Homelessness Status**

Client has been continuously homeless for one (1) year or more **OR** has had four (4) or more episodes of homelessness in the last three (3) years where the combined length of time homeless on those occasions equals 12 months or more **AND** has a documented disabling condition.

Yes (If yes, add "C" to final score below)     No     Unable to determine

	<b>SUBTOTAL</b>
<b>If client indicates they slept and/or will sleep in a place not meant for human habitation, a safe haven, or in an emergency shelter, then score 1.</b>	
<b>If client acknowledges experiencing domestic violence in the last 30 days, then score 1.</b>	
<b>If 18 – 24 years, then score 1.</b>	
<b>If 60 or older, then score 2.</b>	
<b>If client indicates they have served one active day in the military, then score 1.</b>	
<b>If client indicates that they have no income OR only receives DSS assistance, then score 1.</b>	
<b>If client indicates a criminal history, and/or current probation or parole status, then score 1.</b>	
<b>If client indicates having limitations on where they can live due to sex offender status, probation/parole, domestic violence or handicap disability, then score 2.</b>	
<b>If client is pregnant, then score 1.</b>	
<b>If client indicates that they have been homeless due to eviction, utility shut-off, or Code Enforcement 3 or more times in last 2 years, then score 1.</b> <i>- Provide documentation when possible</i>	
<b>If client has a documented disability, score 1.</b>	
<b>If client has 2 or more documented disabilities, score 1.</b>	
<b>If recent involvement with Child Protective, Adult Protective, Juvenile Justice, Family Court, Foster Care, then score 1.</b>	
<b>Additional Points Section (2 point maximum):</b> <b>Use explanation box below to explain your reasoning for adding additional points</b> <ul style="list-style-type: none"> <li>• <i>Points may not be given for conditions previously captured within Coordinated Entry intake.</i></li> <li>• <i>Additional points may be subject to change based upon review of explanation.</i></li> <li>• <i>No points given if explanation box left blank.</i></li> </ul> <b>Include explanation here or attach to referral:</b>     	
<b>TOTAL NUMBER OF POINTS</b> <i>If documented chronic homeless status, add "C" to score. Example: "4C"</i>	

Person completing referral: \_\_\_\_\_ Agency: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## VULNERABILITY INDEX SCORING FOR FAMILIES

### **Chronic Homelessness Status**

Client has been continuously homeless for one (1) year or more **OR** has had four (4) or more episodes of homelessness in the last three (3) years where the combined length of time homeless on those occasions equals 12 months or more **AND** has a documented disabling condition.

Yes (If yes, add "C" to final score below)     No     Unable to determine

**SUBTOTAL**

**If household indicates they slept and/or will sleep in a place not meant for human habitation, a safe haven, or in an emergency shelter, then score 1.**

**If household acknowledges experiencing domestic violence in the last 30 days, then score 1.**

**If head of household is/are 18 – 24 years, then score 1.**

**If head of household is/are 60 or older, then score 2.**

**If any household member indicates they have served one active day in the military, then score 1.**

**If client indicates that their household has no income OR only receives DSS assistance, then score 1.**

**If client indicates a criminal history, and/or current probation or parole status, for self or any member of the household, then score 1.**

**If client indicates any household member having limitations on where they can live due to sex offender status, probation/parole, domestic violence or handicap disability, then score 2.**

**If client indicates self or any member of household is pregnant, then score 1.**

**If client indicates that household has been homeless due to eviction, utility shut-off, or Code Enforcement 3 or more times in last 2 years, then score 1**  
*- Provide documentation when possible*

**If head of household has a documented disability, score 1.**

**If head of household has 2 or more documented disabilities, score 1.**

**If other members of the household (not head) have a documented disability, then score 1.**

**If recent involvement with Child Protective, Adult Protective, Juvenile Justice, Family Court, Foster Care, then score 1.**

**Additional Points Section (2 point maximum):**

**Use explanation box below to explain your reasoning for adding additional points**

- *Points may not be given for conditions previously captured within Coordinated Entry intake.*
- *Additional points may be subject to change based upon review of explanation.*
- *No points given if explanation box left blank.*

**Include explanation here or attach to referral:**

**TOTAL NUMBER OF POINTS**

*If documented chronic homeless status, add "C" to score. Example: "4C"*

Person completing referral: \_\_\_\_\_ Agency: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_