



Smart Path Assessment- Transition Age Youth

**Santa Cruz County
Homeless Management Information System**

**CLIENT INFORMED CONSENT &
RELEASE OF INFORMATION AUTHORIZATION**

_____ is a Partner Agency in the Homeless Management Information System (HMIS). HMIS is a computerized system that can improve programs for homeless persons by allowing information to be shared among partner agencies that provide services such as shelter and health care and/or homelessness research or administrative services. The system is Internet-based and uses many security protections to ensure confidentiality. Partner agencies currently include:

- | | |
|--|--|
| Adult Protective Services | Wings Homeless Advocacy |
| Behavioral Health | Association of Faith Communities |
| City of Santa Cruz | Community Action Board of Santa Cruz |
| Downtown Streets Team | Department of Veterans Affairs |
| Employment and Benefit Services | Encompass |
| Homeless Garden Project | Encompass HOPWA - PRIVATE |
| Homeless Outreach Proactive Engagement (HOPES) | Families In Transition |
| Housing Choices | Front St |
| Janus of Santa Cruz | Homeless Persons Health Project |
| Mental Health Client Action Network | Homeless Services Center |
| Mountain Community Resources | Pajaro Rescue Mission |
| Salud Para La Gente | Pajaro Valley Shelter Services |
| Santa Cruz Community Health Centers | Salvation Army (Watsonville) |
| Santa Cruz Public Libraries | Santa Cruz County Human Services Department- CHAMP |
| Whole Person Care Program | Veterans Resource Center |

Participation in the HMIS program is important to our community's ability to provide you with the best services and housing possible. As you receive services, information will be collected about you, the services provided to you, and the outcomes these services help you to achieve. Your name and other identifying information will not be shared with any agency not participating in the system (unless required to do so by law.) Authorizing your information to be entered into the HMIS is voluntary. Refusing to do so will not limit your access to shelter or services.

I give authorization for my basic and relevant information to be entered _____ **(please initial)** and shared _____ **(please initial)** between Partner Agencies in order to help assist me in obtaining permanent housing, employment, financial assistance, vocational services, counseling and medical/mental health treatment and for research and administrative purposes. (Basic information includes intake date, name, social security number, gender, birth date, ethnicity, marital status, number in household, military status, primary language spoken, and non-confidential services requested and received.) I understand that I have the right to receive a copy of all information shared between the Partner Agencies.

I understand that the current list of participating Partner Agencies may change over time to include other agencies who provide housing or services to the homeless population, and I give authorization for my information to be shared with any new Partner Agency. _____ **(please initial)**

I understand that I may request a current list of all Partner Agencies at any time. I understand that I may cancel this authorization at any time by written request, but that the cancellation will not be retroactive. I understand that this release is valid for three years from the date of my signature below.

Print Name of Client or Guardian

Signature Of Client Or Guardian

Date

Note: A separate, HIPAA-compliant authorization is required for disclosure of any patient health information, including mental health and drug and alcohol information protected by any State or Federal privacy law including, but not limited to, Health Insurance Portability and Accountability Act ("HIPAA"), 45 C.F.R. parts 160 and 164, California Confidentiality of Medical Information Act ("CMIA"), Civil Code sections 56-56.16, Welfare and Institutions Code section 5328, or 42 C.F.R part 2.1, et seq.



HMIS # _____
 CM Name _____
 Date ____/____/____

Santa Cruz County HMIS- New Client Form

This form is designed to be completed by a service provider while interviewing a client.
 A separate form should be completed for each member of the household.

Household Information Is client: Single Adult Adult in Household

If checked Single Adult	Go to Client Profile	
If checked Adult in Household	Are you the Head of Household (HoH)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you are in a household, what is your relationship to the HoH?	<input type="checkbox"/> Wife <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Roommate <input type="checkbox"/> Grandchild	<input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Niece <input type="checkbox"/> Nephew <input type="checkbox"/> Grandparent <input type="checkbox"/> Significant Other <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Spouse <input type="checkbox"/> Other

Client Profile

Social Security Number		
First Name	Middle	
Last Name		
Alias (If multiple aliases, separate by commas)		
Quality of Name	<input type="checkbox"/> Full Name Reported <input type="checkbox"/> Partial, Street Name, or Code Name Reported	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
U.S. Military Veteran (If Yes, complete Veteran Information below)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Disabling Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Primary Phone Number		

Client Demographics

Date of Birth	____ / ____ / ____	
Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Trans Female (MTF or Male to Female) <input type="checkbox"/> Trans Male (FTM or Female to Male)	<input type="checkbox"/> Gender Non-Conforming (i.e. not exclusively male or female) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Ethnicity	<input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Veteran Information

U.S. Military Veteran If yes, answer questions below	Year Entered in Military Service (Year) _____	Separated (Year) _____
Theater of Operations: World War II	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Theater of Operations: Korean War	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Theater of Operations: Vietnam War	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Theater of Operations: Persian Gulf War	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Theater of Operations: Afghanistan	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Theater of Operations: Iraq (Iraqi Freedom)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Theater of Operations: Iraq (New Dawn)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Theater of Operations: Other Operations	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Branch of Military	<input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Navy <input type="checkbox"/> Marine	<input type="checkbox"/> Coast Guard <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Discharge Status	<input type="checkbox"/> Honorable <input type="checkbox"/> General Under Honorable Conditions <input type="checkbox"/> Under Other Than Honorable Conditions (OTH) <input type="checkbox"/> Bad Conduct	<input type="checkbox"/> Dishonorable <input type="checkbox"/> Uncharacterized <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused

Disabling Conditions and Barriers

Does the client have a disabling condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
If Yes, please complete the following for each disability type		
Alcohol Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	Condition Long Term? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, If the problem is expected to be of long-continued and indefinite duration and substantially impedes a client's ability to live independently.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	Condition Long Term? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, If the problem is expected to be of long-continued and indefinite duration and substantially impedes a client's ability to live independently.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Both Alcohol & Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	Condition Long Term? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, If the problem is expected to be of long-continued and indefinite duration and substantially impedes a client's ability to live independently.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Chronic Health Condition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	Condition Long Term? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Developmental Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	Substantially Impairs Independence? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Expected to substantially impair ability to live independently.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Client Location

Address Type	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Mailing <input type="checkbox"/> Emergency <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Spouse	<input type="checkbox"/> Temporary <input type="checkbox"/> Other <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Message <input type="checkbox"/> Management Company <input type="checkbox"/> Forwarding Address <input type="checkbox"/> Encampment <input type="checkbox"/> Tunnel
Name of Location		
Address (line 1)		
Address (line 2)		
City	State	
Zip Code		
Email		
Phone #1		
Phone #2		

Additional Client Location

Address Type	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Mailing <input type="checkbox"/> Emergency <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Spouse	<input type="checkbox"/> Temporary <input type="checkbox"/> Other <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Message <input type="checkbox"/> Management Company <input type="checkbox"/> Forwarding Address <input type="checkbox"/> Encampment <input type="checkbox"/> Tunnel
Name of Location		
Address (line 1)		
Address (line 2)		
City	State	
Zip Code		
Email		
Phone #1		
Phone #2		

I, (Adult client or Head of Household) certify that the information I have provided here is true/correct to the best of my knowledge.

Print Name of Client

Signature of Client

Date

Print Name of Intake Worker

Signature of Intake Worker

Date



Date ____/____/____

Smart Path Additional Questions

First Name _____ **Middle** _____

Last Name _____

- Who is in your household?
 - One or more adults with children over 18 in the household, select one VI-SPDAT per person
 - One or more adults with minor children in custody, select one VI-F-SPDAT
 - Single adult, select the VI-SPDAT
 - Adult couple, select two separate VI-SPDATs
 - Young adult 18-24, select the VI-TAY-SPDAT

- Are you expecting any changes in your family structure?

Yes No

Comment:

- Are you willing to participate in a drug and alcohol-free housing program?

Yes No

- Are you working with a case manager at any agencies?

Yes No

- If so, what is the name of the agency and case manager?

Agency: _____ Case Manager: _____

Administration

Interviewer's Name _____	Agency _____	<input type="checkbox"/> Team <input type="checkbox"/> Staff <input type="checkbox"/> Volunteer
Survey Date DD/MM/YYYY ___/___/____	Survey Time ___ : __ AM/PM	Survey Location _____

Opening Script

Every assessor in your community regardless of organization completing the VI-SPDAT should use the same introductory script. In that script you should highlight the following information:

- the name of the assessor and their affiliation (organization that employs them, volunteer as part of a Point in Time Count, etc.)
- the purpose of the VI-SPDAT being completed
- that it usually takes less than 7 minutes to complete
- that only “Yes,” “No,” or one-word answers are being sought
- that any question can be skipped or refused
- where the information is going to be stored
- that if the participant does not understand a question that clarification can be provided
- the importance of relaying accurate information to the assessor and not feeling that there is a correct or preferred answer that they need to provide, nor information they need to conceal

Basic Information

First Name _____	Nickname _____	Last Name _____
In what language do you feel best able to express yourself? _____		
Date of Birth DD/MM/YYYY ___/___/____	Age _____	Social Security Number _____
		Consent to participate <input type="checkbox"/> Yes <input type="checkbox"/> No

IF THE PERSON IS 17 YEARS OF AGE OR LESS, THEN SCORE 1.

SCORE:

A. History of Housing and Homelessness

1. Where do you sleep most frequently? (check one)

- Shelters **Couch surfing** **Other (specify):**
 Transitional Housing **Outdoors**
 Safe Haven **Refused**

IF THE PERSON ANSWERS ANYTHING OTHER THAN "SHELTER", "TRANSITIONAL HOUSING", OR "SAFE HAVEN", THEN SCORE 1. **SCORE:**

2. How long has it been since you lived in permanent stable housing? _____ Refused

3. In the last three years, how many times have you been homeless? _____ Refused

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

B. Risks

4. In the past six months, how many times have you...

- a) Received health care at an emergency department/room? _____ Refused
b) Taken an ambulance to the hospital? _____ Refused
c) Been hospitalized as an inpatient? _____ Refused
d) Used a crisis service, including sexual assault crisis, mental health crisis, family/intimate violence, distress centers and suicide prevention hotlines? _____ Refused
e) Talked to police because you witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told you that you must move along? _____ Refused
f) Stayed one or more nights in a holding cell, jail, prison or juvenile detention, whether it was a short-term stay like the drunk tank, a longer stay for a more serious offence, or anything in between? _____ Refused

IF THE TOTAL NUMBER OF INTERACTIONS EQUALS 4 OR MORE, THEN SCORE 1 FOR EMERGENCY SERVICE USE. **SCORE:**

5. Have you been attacked or beaten up since you've become homeless? **Y** N Refused

6. Have you threatened to or tried to harm yourself or anyone else in the last year? **Y** N Refused

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

7. Do you have any legal stuff going on right now that may result in you being locked up, having to pay fines, or that make it more difficult to rent a place to live? **Y** N Refused
8. Were you ever incarcerated when younger than age 18? **Y** N Refused

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

9. Does anybody force or trick you to do things that you do not want to do? **Y** N Refused
10. Do you ever do things that may be considered to be risky like exchange sex for money, food, drugs, or a place to stay, run drugs for someone, have unprotected sex with someone you don't know, share a needle, or anything like that? **Y** N Refused

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

C. Socialization & Daily Functioning

11. Is there any person, past landlord, business, bookie, dealer, or government group like the IRS that thinks you owe them money? **Y** N Refused
12. Do you get any money from the government, an inheritance, an allowance, working under the table, a regular job, or anything like that? Y **N** Refused

IF "YES" TO QUESTION 11 OR "NO" TO QUESTION 12, THEN SCORE 1 FOR MONEY MANAGEMENT. **SCORE:**

13. Do you have planned activities, other than just surviving, that make you feel happy and fulfilled? Y **N** Refused

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

14. Are you currently able to take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water and other things like that? Y **N** Refused

IF "NO," THEN SCORE 1 FOR SELF-CARE. **SCORE:**

15. Is your current lack of stable housing...

- a) Because you ran away from your family home, a group home or a foster home? **Y** N Refused
- b) Because of a difference in religious or cultural beliefs from your parents, guardians or caregivers? **Y** N Refused
- c) Because your family or friends caused you to become homeless? **Y** N Refused
- d) Because of conflicts around gender identity or sexual orientation? **Y** N Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **SOCIAL RELATIONSHIPS**.

SCORE:

- e) Because of violence at home between family members? **Y** N Refused
- f) Because of an unhealthy or abusive relationship, either at home or elsewhere? **Y** N Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **ABUSE/TRAUMA**.

SCORE:

D. Wellness

- 16. Have you ever had to leave an apartment, shelter program, or other place you were staying because of your physical health? **Y** N Refused
- 17. Do you have any chronic health issues with your liver, kidneys, stomach, lungs or heart? **Y** N Refused
- 18. If there was space available in a program that specifically assists people that live with HIV or AIDS, would that be of interest to you? **Y** N Refused
- 19. Do you have any physical disabilities that would limit the type of housing you could access, or would make it hard to live independently because you'd need help? **Y** N Refused
- 20. When you are sick or not feeling well, do you avoid getting medical help? **Y** N Refused
- 21. Are you currently pregnant, have you ever been pregnant, or have you ever gotten someone pregnant? **Y** N Refused

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

SCORE:

NEXT STEP TOOL FOR HOMELESS YOUTH

SINGLE YOUTH

AMERICAN VERSION 1.0

22. Has your drinking or drug use led you to being kicked out of an apartment or program where you were staying in the past? **Y** N Refused
23. Will drinking or drug use make it difficult for you to stay housed or afford your housing? **Y** N Refused
24. If you've ever used marijuana, did you ever try it at age 12 or younger? **Y** N Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR SUBSTANCE USE.

SCORE:

25. Have you ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of:
- a) A mental health issue or concern? **Y** N Refused
- b) A past head injury? **Y** N Refused
- c) A learning disability, developmental disability, or other impairment? **Y** N Refused
26. Do you have any mental health or brain issues that would make it hard for you to live independently because you'd need help? **Y** N Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR MENTAL HEALTH.

SCORE:

IF THE RESPONENT SCORED 1 FOR PHYSICAL HEALTH AND 1 FOR SUBSTANCE USE AND 1 FOR MENTAL HEALTH, SCORE 1 FOR TRI-MORBIDITY.

SCORE:

27. Are there any medications that a doctor said you should be taking that, for whatever reason, you are not taking? **Y** N Refused
28. Are there any medications like painkillers that you don't take the way the doctor prescribed or where you sell the medication? **Y** N Refused

IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR MEDICATIONS.

SCORE:

Scoring Summary

DOMAIN	SUBTOTAL	RESULTS
PRE-SURVEY	/1	Score: Recommendation: 0-3: no moderate or high intensity services be provided at this time 4-7: assessment for time-limited supports with moderate intensity 8+: assessment for long-term housing with high service intensity
A. HISTORY OF HOUSING & HOMELESSNESS	/2	
B. RISKS	/4	
C. SOCIALIZATION & DAILY FUNCTIONS	/4	
D. WELLNESS	/6	
GRAND TOTAL:	/17	

Follow-Up Questions

On a regular day, where is it easiest to find you and what time of day is easiest to do so?	place: _____ time: ___ : ___ or Morning/Afternoon/Evening/Night
Is there a phone number and/or email where someone can get in touch with you or leave you a message?	phone: (____) _____ - _____ email: _____
Ok, now I'd like to take your picture so that it is easier to find you and confirm your identity in the future. May I do so?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused

Communities are encouraged to think of additional questions that may be relevant to the programs being operated or your specific local context. This may include questions related to:

- military service and nature of discharge
- ageing out of care
- mobility issues
- legal status in country
- income and source of it
- current restrictions on where a person can legally reside
- children that may reside with the youth at some point in the future
- safety planning



Assessment Specialist

Field for the Assessment Specialist, not a required field:

1. There are significant concerns with this VI-SPDAT score. It is suggested that a full SPDAT be conducted should this client be referred to a housing program.
 This score seems significantly high. This score seems significantly low.

Comment:

2. Is this client a participant in the Dignity Health Passport to Health High Utilizer Program?
 Yes No



Date ____/____/____

Smart Path Non-Housing Resources

Select all categories of non-housing resources to which you referred the participant:

- Basic Needs (meals, food pantry, clothing, showers, emergency shelter)
- Health Services (medical services, mental health services, dental services, substance use disorder services)
- Government Benefits (Medi-Cal, SSI, General Assistance, TANF, CalFresh)
- Other (employment programs, personal identification (ID, birth certificate, Social Security Card), free phone, mail services, transportation (bus passes))



Smart Path Check In

Date ____ / ____ / ____	Date ____ / ____ / ____	Date ____ / ____ / ____
Date ____ / ____ / ____	Date ____ / ____ / ____	Date ____ / ____ / ____
Date ____ / ____ / ____	Date ____ / ____ / ____	Date ____ / ____ / ____
Date ____ / ____ / ____	Date ____ / ____ / ____	Date ____ / ____ / ____
Date ____ / ____ / ____	Date ____ / ____ / ____	Date ____ / ____ / ____



Date ____/____/____

Client Notes

A large rectangular area enclosed by a dotted border, containing 20 horizontal lines for writing notes.