

Ramsey Coordinated Entry Step 2

Client Name: _____ HMIS ID: _____

ASSESSOR INSTRUCTIONS: Please read or paraphrase the following to the client.

I work for (name of your agency) and we are going to complete a Step 2 assessment. This will give me a better idea of what your housing and service needs are. If you say it is ok to continue, I will ask you questions about your health and housing. If you do not understand a question, please say so. I can help explain what is being asked. Some of the questions may be personal, but you will only need to answer yes/no. I don't need specific details. The questions are not meant to judge you, but to assess your needs at this time. If you feel uncomfortable you can take a break or skip a question. If you do not answer a question, no one will be upset with you. But, this information is important to help decide if you are eligible for service, so skipped or inaccurate answers may affect your eligibility. This information will help determine your eligibility and connect you to housing/services. At any time, you can ask that the information you are giving me not be shared. If at any time you are unhappy with the assessment process and/or resulting score or you feel you were treated unfairly, you have the right to let us know.

You can submit a grievance to a staff person (assessor's agency), and the grievance will be looked at by a team working with the Coordinated Entry process. Do you want to continue?

SECTION 1: Assessor Info:

Date of Assessment	Assessment Location (In-person, phone, etc.)	Assessment Type

Current Living Situation

Information Date	Current Living Situation (Shelter, Place not meant for habitation, Staying with family, friends, etc.)

Assessor's Name	Assessor's Organization	Assessor's Phone	Assessor's Email

SECTION 2: Client Contact Information

Phone number where you can be reached or a message can be left:	
Email where you can be reached or where a message can be sent:	
Can we leave a confidential voicemail or text for you at the phone?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Client Name: _____

Secondary Contact Information

Name:	Name:
Phone:	Phone:
Email:	Email:
Relationship:	Relationship:
Can we speak with these contacts to leave info for you?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 3: Background Information

HMIS ROI Signed? <input type="checkbox"/> Yes <input type="checkbox"/> No – Agency ROI Needed
Client Relationship to Head of Household:
Social Security Number:
Client Date of Birth:
Gender Identity: <input type="checkbox"/> (Girl, if child) <input type="checkbox"/> Man (Boy, if child) <input type="checkbox"/> Culturally Specific Identity (e.g. Two-Spirit) <input type="checkbox"/> Transgender <input type="checkbox"/> Non-binary <input type="checkbox"/> Questioning <input type="checkbox"/> Different Identity <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer *If Different Identity, please specify: _____
Gender Pronouns: <input type="checkbox"/> She/her/hers <input type="checkbox"/> He/him/his <input type="checkbox"/> They/them/their <input type="checkbox"/> Zie/hir/hirs <input type="checkbox"/> No pronouns – use person's name <input type="checkbox"/> Other, fill in: _____

Race:	<input type="checkbox"/> American Indian, Alaska Native, or Indigenous <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black, African American, or African <input type="checkbox"/> Hispanic, Latina/e/o <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Prefers not to answer Additional Race & Ethnicity Detail: _____
Are you Native American?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, of which tribe are you an enrolled member? _____

Translation Assistance Needed: Yes No Client doesn't know Client prefers not to answer

Preferred Language: _____

If different preferred language, please specify: _____

Enrollment CoC: Hennepin Ramsey Southeast SMAC Northeast Central
 Northwest West Central St. Louis West Central

County where client resides: _____ **Client Location (CoC):** _____

*The question "County of Primary (Current) Residence" is included here for report compatibility purposes. Answer that question with the same value selected for "County where resides."

Did you serve on Active Duty/National Guard/Reserves? Yes No If yes, answer below:

For approximately how many months did you serve?	_____
Did you enter Active Duty before 9/7/1980?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Guard or Reserve: Were you ever called into active duty as a member of the National Guard or Reservist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What kind of discharge did you have?	<input type="checkbox"/> Honorable/Under honorable conditions <input type="checkbox"/> Other than honorable but not dishonorable <input type="checkbox"/> Dishonorable <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
Client been referred to the Homeless Veteran Registry ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Client record checked against the VA Squares database?	<input type="checkbox"/> Yes <input type="checkbox"/> No
SQUARES:	<input type="checkbox"/> No, could not confirm veteran status <input type="checkbox"/> Yes, confirmed veteran <input type="checkbox"/> Did not check SQUARES

School/Work

Currently in school or working on any degree? Yes, full-time Yes, part-time No
 Are you willing and able to work? Yes No

SECTION 4: Household Composition

Household Type	<input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Youth – Single <input type="checkbox"/> Youth – Family
Household Size: Total # of Persons	
Household Size: Total # of Children (17 and under):	
Household Size: Total # of Adults (18+)	
Are you pregnant?	
If yes, Projected Due Date	

Client Name: _____

Additional Household Members – Additional space in Notes if needed.

Relationship to HoH	Race	Hispanic/Latin(a)(o)(x)?	Gender	Date of Birth	School/Daycare (Ramsey Co. Only)
		<input type="checkbox"/> Yes <input type="checkbox"/> No			
		<input type="checkbox"/> Yes <input type="checkbox"/> No			
		<input type="checkbox"/> Yes <input type="checkbox"/> No			

Is there anyone else you plan to live with? Yes No If yes, please explain:

SECTION 5: Income

Income from Any Source?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, Total Household Monthly Income:	
If \$0 income, will you have income in the next month?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is the expected amount of that income?	

HoH Income Chart

Source of Income – HoH	Monthly Amount

Other Household Members Income Chart

Source of Income	Monthly Amount

HoH Non-Cash Benefit Chart

Non-Cash benefit from any source? Yes No

If yes, from which county are you receiving non-cash benefits? _____

Source of Non-Cash Benefit – HoH Only

SECTION 6: Domestic Violence/Trafficking Script: Some housing resources are targeted for people who have experienced domestic or sexual violence – past or present. These next questions are about that. They are mostly yes/no questions and don't need details.

Is anyone CURRENTLY trying to harm you, control your daily activities, resources, and/or documents, or force you to do things you don't want to do?	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the past, has anyone ever tried to harm you, control you, or force you in those ways?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been involved in dancing, stripping, prostitution, massage, porn, survival sex, or trafficking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(If applicable) How long have you been thinking about leaving? (To establish length of time homeless – Please enter the date they started thinking about leaving)	_____

Script: Thank you for sharing with me. There are advocacy resources available for both people who are currently experiencing violence as well as those who experienced it in the past. You deserve to be safe and have support around you. I can provide you with contact information for an advocate or we can call them right now. (Day 1 number is 866-223-1111)

SECTION 7: Health Information

NOTE: Please include the names of any relevant service providers in Section 11 of this CES Assessment.

Does client have a disability of long duration?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, have you been told by a medical professional that you have a severe mental illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No

HoH Disability Chart

Disability Type (Mental Health, Alcohol Abuse, Drug Abuse, Both Alcohol and Drug Abuse, Physical, Developmental, HIV/AIDS, Chronic Health Condition)	Is it documented?	Expected to be of long-continued and infinite duration and substantially impairs ability to live independently?

Other Household Members Disability Chart

Client Name: _____

Relationship to HoH	Disability Type	Date of Diagnosis	Does your disability limit your ability to live independently?	Is the disability documented?

What accommodation do you require due to health or disability? _____

SECTION 8: Homeless/Housing History

Directions: Please include housing and homeless history for the last 3-5 years. Having this much time documented included allows us to determine if the individual meets the LTH and/or HUD Chronic Homeless definitions.

Move-In Date	Move-Out Date	Residence Type	County/City

Assessing MN Long Term Homelessness

Extent of Homelessness by MN's definition:	<input type="checkbox"/> 1 st time homeless and less than 1 year without a home <input type="checkbox"/> Multiple times homeless, but NOT meeting LTH definition <input type="checkbox"/> Long Term Homeless
Approx. Start Date of MOST RECENT Episode of Homelessness (MN): _____ / _____ / _____	
Total number of months homeless on the street, in ES, in SH, or doubled up/couch-hopping in the past 3 years . Note: Do not factor in months spent staying somewhere that is considered a neutral event (e.g. TH).	

Assessing Chronic Homelessness (HUD) * HUD does NOT include couch hopping. *

Prior Living Situation (where client stayed the night before assessment):	
Length of Stay in Previous Place:	
Approx. Start Date of MOST RECENT Episode of (HUD) Homelessness	_____ / _____ / _____
Regardless of where they stayed last night - Number of times client has been on the streets or in shelters in the past 3 years including today:	
Total # months homeless on the street or in shelter in the past 3 years :	
Housing Status:	<input type="checkbox"/> Category 1: HUD Homeless <input type="checkbox"/> Category 2: At imminent risk of losing housing <input type="checkbox"/> Category 4: Fleeing domestic violence (Category 3 is not used and was omitted intentionally) <input type="checkbox"/> At risk of losing homelessness <input type="checkbox"/> Stably housed <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
Clients ages 16 - 22 only: Is there another safe place you could stay, including staying with someone else (friend, neighbor, family)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Client Name: _____

Barriers to Housing

Do you owe money to any past landlords?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you owe any money to PHA?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any past due utilities payments?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes to any of these, please include details here:	

SECTION 9: Legal History

Note: Please add any current case worker information to Section 11: Provider Involvement.

Do you have a legal/criminal history? Yes No If yes, please complete this chart.

Relationship to HoH	Offense Type (Drug, Arson, Sex Offense, Violent Crime, NonViolent Crime)	Classification (Felony, Misdemeanor)	Number of Offenses	Date of Most Recent Conviction	Active warrant or any open criminal case?	If sex offense, registered sex offender?
				/_/_/		
				/_/_/		
				/_/_/		

SECTION 10: Housing Preferences

Are you willing to live anywhere in the 7 county metro area? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please rank up to 5 counties that you would prefer to live in. 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Please indicate CoC based on client preferences. If the client identifies a CoC outside of their current residence, notify the Priority List Manager: SMAC Ramsey Hennepin Other:



Specific Services:

Are you willing to consider or are you interested in programs that:

Utilize Housing Support (formerly GRH) funding to cover the cost of housing & services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Offer shared housing or SROs (ie you have your own bedroom but may share kitchen,	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have a front desk that helps monitor visitors?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Provide a sober, recovery-oriented community (may require UA at intake and randomly	<input type="checkbox"/> Yes <input type="checkbox"/> No

Target Populations

Directions: Let client know that some housing programs serve people from specific cultural backgrounds or with particular life experiences. Some of these are covered elsewhere in the assessment, but this section allows the client to indicate if they would be open to housing programs that serve that specific group.

Tell client: I'm going to read through the list of populations that may be served by specialty programs. For each one, if you identify as being a part of that population, tell me if you would be open to housing within those targeted programs.

African American/Black	<input type="checkbox"/> Yes <input type="checkbox"/> No	People living with chemical health diagnosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
American Indian	<input type="checkbox"/> Yes <input type="checkbox"/> No	People living with HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Latinx	<input type="checkbox"/> Yes <input type="checkbox"/> No	People living with Severe & Persistent Mental Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No
LGBTQ+ Youth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Survivors of trafficking or sexual exploitation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Multi-Racial Households	<input type="checkbox"/> Yes <input type="checkbox"/> No	Veterans	<input type="checkbox"/> Yes <input type="checkbox"/> No

Client Name: _____

SECTION 11: Provider Involvement

Directions: Please list all social service providers who client is currently working with. This could be targeted case management or other forms of social services, financial, mental health, vocation, veteran, child protection, etc.

Provider Type	County	Worker Agency	Worker Name	Worker Contact

Are you working with ACT, CTI, TCM mental health worker?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Were you ever in foster care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently in foster care or a ward of the state?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes to either, did you exit foster care at or after the age of 16?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Housing Documentation Status

Do you have a photo ID?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> In-progress
Do you have your Social Security card?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> In-progress
Do you have your birth certificate?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> In-progress
Housing documentation notes:			

Additional Notes:

DHS Housing Stabilization Services Coordinated Entry Document

Client Name:

Client HMIS ID:

This document shows that a person has an assessed need and housing instability for Housing Stabilization Services, which represent part of the eligibility requirements for these services.

Client Information

Date of Birth:

Phone Number where you can be reached or where a message can be left:

Email where you can be reached or where a message can be sent:

Eligibility Questions

The following series is required to help determine eligibility for DHS Housing Stabilization Service. Based on your experience with the person you have assessed for Coordinated Entry, review the following 5 questions and use your professional judgement when selecting your responses.

Question	Explanation	Answer
<p>1. Housing Instability: Is the person experiencing housing instability?</p>	<p>Yes indicates person has reported their current housing situation as one of the following:</p> <ul style="list-style-type: none"> • Homeless (the person lacks a fixed, adequate nighttime residence) • At risk of homelessness (the person is faced with a situation that may cause them to become homeless) • Transitioning or recently transitioned from an institution, licensed, or registered setting 	<p>Yes No Unsure/ Unable to answer</p>
<p>2. Communication: Does this person need support communicating their needs to help with housing?</p>	<p>Yes indicates you observe at least one of the following:</p> <ul style="list-style-type: none"> • Person is difficult for most listeners to understand • Person struggles to understand most speakers • Person uses non-speech method (e.g., sign language, symbols, gestures) to communicate 	<p>Yes No Unsure/ Unable to answer</p>

Question	Explanation	Answer
<p>3.</p> <p>Mobility: Does this person need support getting around to help with housing?</p>	<p>Yes indicates you observe at least one of the following:</p> <ul style="list-style-type: none"> • Person needs assistance or supervision to use transportation • Person walks with physical assistance from another person • Person does not typically walk • Person requires assistance from another person to complete tasks requiring fine motor skills such as reading, writing, or maintaining personal care • Person cannot walk for long periods without taking breaks 	<p>Yes</p> <p>No</p> <p>Unsure/ Unable to answer</p>
<p>4.</p> <p>Decision Making: Does this person need support managing moods or behaviors to help with housing?</p>	<p>Yes indicates you observe at least one of the following:</p> <ul style="list-style-type: none"> • Person has reported significant short-term memory issues or confusion retaining or recalling recent events, experiences, skills, or information • Person shows confusion or disorientation when asked about themselves • Person cannot weigh positives and negatives of issue in order to make appropriate decision • Person is easily coerced into decisions that may not benefit them 	<p>Yes</p> <p>No</p> <p>Unsure/ Unable to answer</p>
<p>5.</p> <p>Managing Challenging Behaviors: Does this person need support managing challenging behaviors to help with housing?</p>	<p>Yes indicates you observe at least one of the following:</p> <ul style="list-style-type: none"> • Person exhibits behaviors that may require supports to prevent/mitigate breaking the law • Person would have difficulty to identify and problem-solve to take appropriate action without assistance in a potentially harmful situation • Person requires the availability of an identified/dedicated person to safely direct own activities and manage personal responsibilities 	<p>Yes</p> <p>No</p> <p>Unsure/ Unable to answer</p>

If yes to the question regarding housing instability, and yes to any of the remaining questions, the individual meets the Assessed Need and Housing Instability observations for DHS Housing Stabilization Services.

