

WI BALANCE OF STATE CoC Pre-Screen Form



Are you a domestic violence victim or survivor? Yes No
 If yes, would you like a referral to a local DV agency? Yes No
 If yes, when last experience occurred? _____
 If yes, are you currently fleeing a domestic violence situation? Yes No

Do you have a disability or need reasonable accommodations for us to provide services to you, including filling out this form? (this question is voluntary and does not affect your eligibility for services) Yes No

List Accommodations needed:

Do you need an interpreter? Yes No Language? _____

Household members (List everyone living in your household, related & unrelated)

Head of Household						
Last	First	Middle	Gender	<input type="checkbox"/> Disabled	Date of birth / /	
_____	_____	_____	_____	<input type="checkbox"/>	____/____/____	
_____	_____	_____	_____	<input type="checkbox"/>	____/____/____	
_____	_____	_____	_____	<input type="checkbox"/>	____/____/____	
_____	_____	_____	_____	<input type="checkbox"/>	____/____/____	
_____	_____	_____	_____	<input type="checkbox"/>	____/____/____	

Current Address: _____
 Street Apt. # City State Zip Code

Telephone No: _____ Email: _____

Living situation last night

- Emergency shelter, including hotel or motel paid for with emergency shelter voucher
- Place not meant for habitation inclusive of "non-housing service site (outreach programs only)"
- Safe haven

When did this homelessness experience start (not necessarily when you entered shelter)? ___/___/___

- | | |
|--|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> Staying or living in a friend's room, apartment or house <input type="checkbox"/> Rental by client, no housing subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Rental by client, with other housing subsidy (including RRH) <input type="checkbox"/> Jail, prison, or juvenile detention facility <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center | <ul style="list-style-type: none"> <input type="checkbox"/> Other _____ <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Long term care facility or nursing home <input type="checkbox"/> Rental by client with GPD or TIP subsidy <input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital (non-psychiatric) <input type="checkbox"/> Owned by client, no housing subsidy <input type="checkbox"/> Owned by client, with housing subsidy |
|--|--|

WI BALANCE OF STATE CoC Pre-Screen Form



Length of time in last night's living situation:

- | | |
|--|--|
| <input type="checkbox"/> One night or less
<input type="checkbox"/> 2-6 nights
<input type="checkbox"/> One week but less than a month | <input type="checkbox"/> One to three months
<input type="checkbox"/> More than three months, but less than one year
<input type="checkbox"/> One year or longer |
|--|--|

Estimate how much longer you expect to reside there.

- | | |
|---|--|
| <input type="checkbox"/> Can't go back
<input type="checkbox"/> More than a year
<input type="checkbox"/> It's a day-by-day arrangement | <input type="checkbox"/> Until shelter/housing is received
<input type="checkbox"/> Less than 3 months
<input type="checkbox"/> 3 months to a year |
|---|--|

Number of times you have been on the Street, in an Emergency Shelter, on a motel voucher, or in a Safe Haven in the past three years including today: _____ times

Number of months homeless on the Street, in an Emergency Shelter, on a motel voucher, or in a Safe Haven in the past three years: _____ (not exceeding 36 months)

- | | | | |
|-------------------------------|---|---|---|
| Veteran Status | <input type="checkbox"/> Never in the Service | <input type="checkbox"/> Currently in the Service | <input type="checkbox"/> Veteran |
| <i>Veteran Benefit Status</i> | <input type="checkbox"/> Currently receiving | <input type="checkbox"/> Currently not receiving | <input type="checkbox"/> Never received |

Cause of homelessness (check all that apply).

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Divorce/Separation | <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Eviction | <input type="checkbox"/> Thrown out |
| <input type="checkbox"/> Loss of job | <input type="checkbox"/> Low income | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Parole/incarceration | <input type="checkbox"/> Ran Away | <input type="checkbox"/> Exiting Foster care | <input type="checkbox"/> Rent increase |
| <input type="checkbox"/> Other _____ | | | |

FUP Eligible Family _____ **FUP Eligible Youth** _____
**For public child welfare agencies only, FUP eligibility must be determined by the PCWA in your county*

INCOME: (Please list all sources of income)

- | | |
|---------------|-------------------------------|
| Source: _____ | Gross monthly amount \$ _____ |
| Source: _____ | Gross monthly amount \$ _____ |
| Source: _____ | Gross monthly amount \$ _____ |

NO INCOME – Do you certify that you do not have any income from any source at this time?
 Yes No **VERBAL**

Do you give consent that this agency may share information with other agencies such as, but not limited to, your situation, household demographics, and any questions asked during this assessment for the purpose of providing a referral to Coordinated Entry Prioritization Lists?
 Yes No **VERBAL**

I understand that the information contained on this form is provided voluntarily. The information is true and correct to the best of my knowledge. If I provide any false information, I understand that services may be denied. I understand that completion of this form does not guarantee that I will receive assistance.
 VERBAL

Signature of Applicant _____ Date: _____

Signature of CoC Agency Rep _____ Date: _____

NOTES: