

# 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  Disabled Race Ethnicity Date of birth

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Last Name First Name Middle Relationship to HH Gender  Disabled Race Ethnicity Date of birth

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Last Name First Name Middle Relationship to HH Gender  Disabled Race Ethnicity Date of birth

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Last Name First Name Middle Relationship to HH Gender  Disabled Race Ethnicity Date of birth

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Last Name First Name Middle Relationship to HH Gender  Disabled Race Ethnicity Date of birth

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Last Name First Name Middle Relationship to HH Gender  Disabled Race Ethnicity Date of birth

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)? \_\_\_/\_\_\_/\_\_\_

- Hotel or motel paid for without emergency shelter voucher
- Staying or living in a family member's room, apartment or house
- Staying or living in a friend's room, apartment or house
- Rental by client, no housing subsidy
- Rental by client, with VASH housing subsidy
- Rental by client, with other housing subsidy (including RRH)
- Jail, prison, or juvenile detention facility
- Transitional housing for homeless persons (including homeless youth)
- Permanent housing (other than RRH) for formerly homeless persons
- Psychiatric hospital or other psychiatric facility
- Substance abuse treatment facility or detox center
- Other \_\_\_\_\_
- Residential project or halfway house with no homeless criteria
- Long term care facility or nursing home
- Rental by client with GPD or TIP subsidy
- Foster care home or foster care group home
- Hospital (non-psychiatric)
- Owned by client, no housing subsidy
- Owned by client, with housing subsidy

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### Length of living situation in place marked above.

- One night or less
- 2-6 nights
- One week but less than a month
- One to three months
- More than three months, but less than one year
- One year or longer

### Estimate how much longer you expect to reside there.

- Can't go back
- More than a year
- Until shelter/housing is received
- Less than 3 months
- 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  Never in the Service  Currently in the Service  Veteran  
*Veteran Benefit Status*  Currently receiving  Currently not receiving  Never received

### Cause of homelessness (check all that apply).

- Divorce/Separation
- Loss of job
- Parole/incarceration
- Other \_\_\_\_\_
- Domestic Violence
- Low income
- Ran Away
- Eviction
- Mental illness
- Exiting** Foster care
- Thrown out
- Substance abuse
- Rent increase

**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. I am aware that providing false information or not reporting pertinent information is fraud. 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: \_\_\_\_\_