



# WI BALANCE OF STATE CoC Pre-Screen Form

The following questions are voluntary. However, missing or unanswered questions may affect your ability to qualify or prioritize for housing programs.

## Head of Household Contact Information

Self

Last Name First Name Middle Head of Household Sex-M/F Disabled-Y/N Race/Ethnicity D.O.B. Age

Last Name First Name Middle Relationship to HoH Sex-M/F Disabled-Y/N Race/Ethnicity D.O.B. Age

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### Please check which ones are safe to contact:

Phone Number: \_\_\_\_\_  Call  Text  Voicemail

Email: \_\_\_\_\_

Current Address: \_\_\_\_\_

Do you have a chronic disabling condition?  Yes  No

If yes, how many of the following apply? (0-6) \_\_\_\_\_

*\*Note: do not identify/circle any disabling conditions listed below*

Mental Health Disorder  
Physical Disability

Developmental Disability  
Chronic Health Condition

Substance use Disorder  
HIV/AIDS

Do you have non-chronic medical needs?  Yes  No

Do you need reasonable accommodations for us to provide services to you, including filling out this form?  Yes  No

List accommodations needed: \_\_\_\_\_

Translation Assistance Needed:  Yes  No Preferred Language: \_\_\_\_\_

**Veteran Status:** Have you ever served in the military in any capacity?  Yes  No

If there were housing services available for people living with HIV/AIDS, is that something you'd be interested in?                      Yes                      No

If there were housing services available for people recovering from Substance Use Disorders, is that something you'd be interested in?                      Yes                      No

**Living Situation at time of assessment:** *(Cat. 1)*

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

If yes to any of the above situations, what is the approximate date that **this episode of homelessness started?** \_\_\_\_\_

**Living situation at time of assessment:** *(Cat. 2)*

- |  |   |
|--|---|
| <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher       | <input type="checkbox"/> Owned by client, no housing subsidy                                  |
| <input type="checkbox"/> Foster care home or foster care group home                      | <input type="checkbox"/> Owned by client, with housing subsidy                                |
| <input type="checkbox"/> Staying or living in a family member's room, apartment or house | <input type="checkbox"/> Residential project or halfway house with no homeless criteria       |
| <input type="checkbox"/> Staying or living in a friend's room, apartment or house        | <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) |
| <input type="checkbox"/> Rental by client, no ongoing housing subsidy                    |   |
| <input type="checkbox"/> Rental by client, with ongoing housing subsidy                  |   |

Rental Subsidy Type:

- GPD TIP housing subsidy
- VASH Housing subsidy
- RRH or equivalent subsidy
- HCV voucher (tenant or project based) detention (not dedicated)
- Public Housing Unit
- Rental by client, with other ongoing housing Subsidy
- Family Unification Program Voucher (FUP)
- Foster Youth to Independence Initiative (FYI)
- Permanent Supportive Housing
- Other permanent housing dedicated for formerly Homeless person

Other: \_\_\_\_\_

Institutional Setting:

- Psychiatric hospital or other psychiatric facility
- Hospital (non-psychiatric)
- Jail, prison, or juvenile facility
- Substance use treatment facility or detox center
- Long-term care facility or nursing home

**Length of living situation in the place marked above:**

- |   |   |
|---|---|
| <input type="checkbox"/> One night or less              | <input type="checkbox"/> More than three months, but less than one year |
| <input type="checkbox"/> 2-6 nights                     | <input type="checkbox"/> One year or longer                             |
| <input type="checkbox"/> One week but less than a month | <input type="checkbox"/> Client doesn't know                            |
| <input type="checkbox"/> One to three months            | <input type="checkbox"/> Client refused                                 |

**If you stayed somewhere other than emergency shelter, a place not meant for human habitation, or a safe haven, will you have to leave this living situation within 14 days?**

- Yes (answer next 4 questions)
  Client doesn't know (answer next 4 questions)
- No (skip next 4 questions)
  Client prefers not to answer (answer next 4 questions)

**Have you found a new place to live?**

- Yes
  Client doesn't know
- No
  Client prefers not to answer

**Do you have resources or support networks to obtain other permanent housing?**

- Yes
  Client doesn't know
- No
  Client prefers not to answer

**Have you had a lease or other permanent place to live in the last 60 days?**

- Yes
  Client doesn't know
- No
  Client prefers not to answer

**Have you moved 2 or more times in the last 60 days?**

- Yes
  Client doesn't know
- No
  Client prefers not to answer

**Number of times/episodes** you have been on the street, a place not meant for human habitation, in an emergency shelter, or on a motel voucher, or in a Safe Haven **in the past three years**, including today: \_\_\_\_\_ times

**Number of months homeless** on the street, a place not meant for human habitation, in an emergency shelter, on a motel voucher or in a Safe Haven **in the past three years**: \_\_\_\_\_ (not exceeding 36 months)

**Cause(s) of homelessness or housing instability (at-risk):**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Divorce/separation | <input type="checkbox"/> Domestic violence, sexual assault, and/or human trafficking | <input type="checkbox"/> Eviction                     | <input type="checkbox"/> Asked or forced to leave residence |
| <input type="checkbox"/> Loss of job        | <input type="checkbox"/> Low income  | <input type="checkbox"/> Rent increase                | <input type="checkbox"/> Parole/incarceration               |
| <input type="checkbox"/> Mental illness     | <input type="checkbox"/> Substance Use Disorder                                      | <input type="checkbox"/> Ran away                     | <input type="checkbox"/> Exiting foster care                |
| <input type="checkbox"/> Other: _____       | <input type="checkbox"/> Client doesn't know   | <input type="checkbox"/> Client prefers not to answer |   |

**Domestic Violence, Sexual Assault, and/or Human Trafficking**

- Are you a survivor of domestic violence, sexual assault, and /or human trafficking?  Yes  No
- If yes, when did the last experience occur? \_\_\_\_\_
- Would you like a referral to a local victim services agency?  Yes  No
- Are you currently fleeing domestic violence, sexual assault, and/or human trafficking?  Yes  No

**If yes to the question above, answer the following additional questions:**

- How many times have you left or attempted to leave your abusive situation in the last 3 years? \_\_\_\_\_
- What is the approximate date that you began to make plans to look for housing to leave your current abusive situation? \_\_\_\_\_



FUP Eligible Family  Yes  No FUP Eligible Youth  Yes  No

**\*For public child welfare agencies only, FUP eligibility must be determined by the PCWA in your county.**

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 question asked during this assessment **for the purpose of providing a referral to Coordinated Entry Prioritization Lists?**  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 finding a permanent housing solution for you/your family?**  Yes  No  Verbal

**Victim service programs must also follow state and federal confidentiality laws and secure a VAWA-compliant Release of Information and Waiver of non-Disclosure in order to share information.**

I want to be referred to the Coordinated Entry Priority Lists in the following area(s):

- |                                       |  |  |
|---------------------------------------|--|--|
| <input type="checkbox"/> Brown        | <input type="checkbox"/> Kenosha       | <input type="checkbox"/> Rock-Walworth |
| <input type="checkbox"/> Central      | <input type="checkbox"/> Lakeshore     | <input type="checkbox"/> Rural North   |
| <input type="checkbox"/> Coulee       | <input type="checkbox"/> North Central | <input type="checkbox"/> Southwest     |
| <input type="checkbox"/> Dairyland    | <input type="checkbox"/> Northeast     | <input type="checkbox"/> Washington    |
| <input type="checkbox"/> East Central | <input type="checkbox"/> Northwest     | <input type="checkbox"/> Waukesha      |
| <input type="checkbox"/> Fox Cities   | <input type="checkbox"/> NWISH         | <input type="checkbox"/> West Central  |
| <input type="checkbox"/> Jefferson    | <input type="checkbox"/> Ozaukee       | <input type="checkbox"/> WinnebagoLand |

I understand that I am responsible for my own transportation as necessary if I am offered housing services in another area.  Yes  No  Verbal

I understand that being offered housing services in another area does not guarantee immediate access to housing or emergency shelter during housing search.  Yes  No  Verbal

I understand that the information contained in 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.  Yes  No  Verbal

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_  Verbal

Signature of Agency Staff Member \_\_\_\_\_ Date \_\_\_\_\_  
*(signature or typed name of staff member filling out the form)*

Name of Agency \_\_\_\_\_