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Housing Status and Homelessness Screening Tool: Instructions

Purpose of the Housing Status and Homelessness Screening Tool

This screening tool helps behavioral health staff identify a client's current housing status, determine whether they meet applicable behavioral health definitions of homelessness, consistently document that information in the Electronic Health Record (EHR) and, when appropriate, the Homeless Management Information System (HMIS), and connect clients with targeted housing referrals and resources.

Who Should Use This Form?

This screening tool should be used by behavioral health staff that serve individuals who may be experiencing homelessness or housing instability. The tool is intended for staff responsible for identifying client needs, making referrals, documenting housing status, or coordinating care.

The form should be completed by the behavioral health staff member who is best positioned to assess and document the client's housing status. This will vary by county and local workflow.

Depending on the program and setting, this may include:

- Behavioral health case managers
- Outreach workers
- Care coordinators or care managers
- Housing specialists
- Intake or assessment staff
- Clinicians, when housing needs are identified during an assessment or ongoing treatment

Department Workflow Recommendation:
The workflow should be designed so that the first behavioral health staff member who identifies a housing need either:
(1) documents the client's housing status using this form or
(2) ensures the client is connected to the appropriate staff member who can complete the screening. Counties should adapt this workflow to align with their local staffing model, EHR configuration, and HMIS access.

Why Should Behavioral Health Departments Collect Housing Status Information?

Housing is one of the strongest predictors of behavioral health outcomes. Identifying clients experiencing homelessness and housing instability early allows providers to:

- Meet state requirements for use of BHSA dollars.
- Measure the prevalence of homelessness among behavioral health clients and better understand who is experiencing it.
- Meet state and federal reporting requirements.
- Plan services and future housing investments based on demonstrated need.
- Connect clients with appropriate housing resources when available.
- Coordinate and align care across behavioral health and homelessness response systems.

Accurate documentation also helps communities better understand the number of behavioral health clients experiencing homelessness and strengthens planning for future housing investments.

Before completing the form

1. If you have access to HMIS, check to see if there is already a record for the client. **If there is an HMIS record for the client you do not need to complete this form.**
2. Review the client's EHR to familiarize yourself with their records. Remember to avoid asking questions that are already answered by information in the EHR, such as asking for details about disabilities or diagnoses.
3. Review the box to the right with tips for facilitating a trauma-informed conversation.
4. Review the definitions of homelessness, and chronic homelessness included in Appendix A.

Trauma-Informed Tips for Administering the Tool

- *Ask questions in a private setting whenever possible.*
- *Let the client know they may pause, take a break, or decline to answer a question.*
- *Use a calm, conversational tone rather than reading the questions like an interview or checklist.*
- *Avoid judgmental language or assumptions about why the client is experiencing homelessness.*
- *Ask one question at a time and allow the client enough time to respond.*
- *Do not require the client to repeatedly describe traumatic experiences.*
- *Avoid promising housing or services. Explain that the information may help identify appropriate referrals, but resources are limited.*
- *If the client becomes distressed, pause the screening, acknowledge their reaction, and ask what they need before continuing.*
- *Before ending, explain what will happen next and identify any referrals or follow-up steps.*

Instructions: Completing the Housing Status and Homelessness Screening Tool

Step 1: Explain the purpose of the tool to the client

Before asking the questions in the tool to the client, explain its purpose and how the information will be used using the sample script below.

Sample Client Script

"We're going to ask a few questions about your current housing situation. We ask everyone these questions so we can better understand and track the housing needs of people receiving behavioral health services. You can let me know if you need a break or do not feel comfortable answering a question. You can skip questions if you're not comfortable answering. Your answers may help us identify housing programs or resources that could be a good fit. Because housing resources are limited, completing this screening does not guarantee housing, financial assistance, or other services."

Step 2: Ask the client each question on the screening form and record their responses.

Use the client's answers to complete the form as accurately as possible. If the client is unsure of an answer, document the best available information.

Use a trauma-informed approach throughout the screening. Be mindful that questions about housing, safety, or past living situations may be difficult for some clients to answer. If a client becomes distressed or reluctant to continue, acknowledge their feelings, offer to pause or return to the questions later if clinically appropriate, and focus on creating a safe, supportive environment. The goal is to understand the client's current housing needs not to interrogate or challenge their experiences.

When taking the client's housing history (Section 3 of the form), remember that it might be difficult for the client to remember their housing and homeless status over the past three years. See the box to the right for tips on how to facilitate this conversation.

Facilitating a Conversation about Housing History

- *Begin by asking about their current episode of homelessness.*
  - E.g. "How long have you been living in the place that you stayed last night?"
- *Ask about times that the client remembers being housed.*
  - E.g. "When was the last time that you lived in a house or apartment, even if it was someone else's? How long did you live there?"
- *Ask about their housing status during other life events in the past three years.*
  - E.g. "Where were you staying on your last birthday?"

Step 3: Document the tool in HMIS and EHR (see documentation section below)

Step 4: Make any necessary referrals, remembering to do a "warm handoff" whenever possible. (see referral section below)

Documentation of the Tool & Housing Status

HMIS Documentation

If your program has HMIS access, HMIS data entry staff should:

- ❒ Search for the client before creating a new HMIS record.
- ❒ Verify whether the client already has an active enrollment.
- ❒ Update or enter housing information into the HMIS record.
- ❒ Upload a copy of the completed tool.
- ❒ Follow any other local HMIS policies for data entry.

If your program does not have HMIS access, HMIS data entry staff should:

- ❒ Document the client's housing status in the EHR.
- ❒ Connect the client to their local Continuum of Care's Coordinated Entry access point, when appropriate.
- ❒ Document the referral and any follow-up steps in the EHR, as described below.

Referral Best Practice: Whenever possible, make a "warm handoff" by helping the client connect directly with the local Coordinated Entry access point or housing provider, rather than providing referral information alone. Warm handoffs can improve engagement and increase the likelihood that clients successfully access available housing resources.

An example of a warm handoff would be calling the coordinated entry access point with the client in the room after completing the tool, rather than simply giving them the number to call themselves.

EHR Documentation

- ❒ Document housing status by uploading the screening tool to your EHR system.
- ❒ Utilize any other appropriate documentation features within your EHR.
    - (These will depend on how your local system is configured. For example, you might use the problem list to capture homeless status, you might use special population flags or other means to capture chronic homelessness or encampment status.)

Referral Practices

In addition to connecting clients with available behavioral health supportive services & housing resources, staff may refer clients experiencing homelessness or housing instability to a local Continuum of Care (CoC) Coordinated Entry System (CES) access point.

Coordinated Entry is the primary process CoCs use to assess housing needs, prioritize assistance, and connect eligible individuals and families with available HUD-funded housing resources. Access points may also connect people at imminent risk of homelessness with prevention services or other community resources.

Remember: clients experiencing **housing instability** may still have significant housing needs. Consider referrals beyond coordinated entry to:

- Local homelessness prevention rental assistance programs
- Eviction prevention legal services resources.
- Case management or care coordination services.
- Benefits enrollment and income support.
- Other community-based housing and supportive services.

Behavioral health staff are not responsible for making final eligibility determinations for CoC/HUD-funded housing programs. Staff should document the client's housing status, explain the referral process, connect the client with the appropriate access point, and coordinate with housing providers or HMIS staff as needed. A referral to Coordinated Entry does not guarantee housing or financial assistance because eligibility and resource availability vary.

Appendix A: How is Homelessness Defined for BH Clients: BHSA Homelessness Definitions

"Experiencing Homeless" is defined as:

1. An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:
    a. An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;

   b. An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals); or
   c. An individual who is exiting an institution and was considered homeless immediately prior to entering the institution or becomes homeless during the institutional stay, regardless of the length of stay.
2. An individual or family who will imminently lose their primary nighttime residence, provided that:
   a. The primary nighttime residence will be lost within 30 days of the date of application for homeless assistance;
   b. No subsequent residence has been identified; and c. The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, needed to obtain other permanent housing.
3. Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:
   a. Are defined as homeless under section 387 of the Runaway and Homeless Youth Act (42 U.S.C. 5732a), section 637 of the Head Start Act (42 U.S.C. 9832), section 41403 of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2), section 330(h) of the Public Health Service Act (42 U.S.C. 254b(h)), section 3 of the Food and Nutrition Act of 2008 (7 U.S.C. 2012), section 17(b) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)), or section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a); 211
   b. Have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance;
   c. Have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; and
   d. Can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse (including neglect), the presence of a child or youth with a disability, or two or more barriers to employment, which include the lack of a high school degree or General Education Development (GED), illiteracy, low English proficiency, a history of incarceration or detention for criminal activity, and a history of unstable employment.
4. Any individual or family who:
   a. Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence;
   b. Has no other residence; and

c. Lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, to obtain other permanent housing.

"Chronically Homeless"

1. A homeless individual with a disability as defined in section 401, subdivision (9) of the McKinney-Vento Assistance Act (42 U.S.C. section 11360, subdivision (9)), who:
   a. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter, and
   b. Has been homeless on any number of occasions in the last 3 years, as long as the combined occasions equal at least 12 months; or
2. An individual who is exiting an institution and met all of the criteria in paragraph (1) immediately prior to entering the institution regardless of the length of stay; or
3. A family with an adult head of household (or, if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2), including a family whose composition has fluctuated while the head of household has been homeless.

Appendix B: Other Definitions of Homelessness

Behavioral health providers and HUD-funded homelessness programs use different definitions of homelessness because they serve different purposes. Behavioral health programs use broader definitions to identify individuals with housing needs and support treatment planning, care coordination, and service delivery. HUD uses more specific definitions to determine eligibility for federally funded homelessness assistance programs. A client may meet the behavioral health definition of homelessness but not meet HUD eligibility for certain housing programs. The following section can help you understand the HUD definitions.

However, **behavioral health staff are not expected to make final eligibility determinations for HUD-funded programs.** Instead, information in this section is intended to be informative and can help staff recognize when a client may qualify for HUD-funded homelessness assistance and connect them with the local Continuum of Care's Coordinated Entry access point or other appropriate housing staff for a complete eligibility assessment. The relevant HUD homelessness categories are as follows:

Category 1 – Literally Homeless

A person or family who:

- Is living in a place not meant for human habitation.
- Is staying in an emergency shelter or safe haven.
- Is exiting an institution after a stay of 90 days or less and was homeless immediately before entering the institution.

Chronic Homelessness

Chronic homelessness is **not** a separate HUD category. It is an additional designation used to prioritize individuals for Permanent Supportive Housing (PSH).

An individual is considered chronically homeless if they:

- Meet HUD's Category 1 definition of homelessness;
- Have a qualifying disability; **and**
- Have either:
    - Been continuously homeless for at least 12 months, **or**
    - Experienced at least four separate episodes of homelessness in the past three years that total at least 12 months.

For families, the head of household (or another adult household member, as applicable under HUD regulations) must meet the disability and homelessness requirements.

Category 2 – Imminent Risk of Homelessness

A person or family who:

- Will lose their primary nighttime residence within 14 days;
- Has no subsequent residence identified; and
- Lacks the resources or support networks needed to obtain other permanent housing.

Examples include someone with an eviction notice, notice to vacate, or who is being asked to leave by family or friends and has nowhere else to go.

Important: Category 2 does **not** mean the person is currently homeless. It identifies people who are about to become homeless and may be eligible for prevention services.

[1]Category 4 – Fleeing or Attempting to Flee Domestic Violence

A person or family who:

- Is fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, human trafficking, or another dangerous or life-threatening condition related to violence;
- Has no other residence; and
- Lacks the resources or support networks needed to obtain permanent housing.

Individuals meeting Category 4 may be eligible for many HUD-funded homelessness programs even if they are not living in a shelter or outdoors.

[1] Note on Category 3 – Homelessness Under Other Federal Statutes

Category 3, which covers certain unaccompanied youth and families with children who are considered homeless under other federal laws, is not included here because CoC Program funds may be used to serve this population only with HUD's approval and HUD *has not authorized any CoC to serve the homeless under Category 3.*