



HOMELESS OUTREACH WORKER (HOW) SCREENING TOOL

CLIENT INFORMATION

1.	Name:	Last	First	M.I.	Birth date:	Age:	Gender:		
2.	Contact Information:				Contact Number: ()	U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused			
					Language Preference:				
3.	Presenting Problem:								
4.	Linkage:	Program Name:							
		<input type="checkbox"/> BHS Program <input type="checkbox"/> Community Resources							
5.	Is program providing assistance with temporary housing payment?				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused		Verified with CCBH <input type="checkbox"/> Yes <input type="checkbox"/> No		Verified with HMIS <input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Income Source:	Income Amount:			Highest grade or level of education completed:				
7.	Transportation:	<input type="checkbox"/> Independent <input type="checkbox"/> Public		Relevant ID's:					
8.	Domestic violence experienced:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused		Trauma history: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused		Religious preference:			
9.	Optional narrative:								

HEALTH HISTORY

10.	Physical health physician and/or clinic:	Insurance:
11.	Address & contact information for physician and/or clinic	
12.	Physical health condition(s):	
13.	Optional narrative:	

MENTAL HEALTH HISTORY

14.	Are you currently receiving mental health services?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	Where:	
15.	What services are you interested in or willing to receive?			
16.	Have you ever been diagnosed with a mental health condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	Diagnosis:	
17.	Has anyone ever told you that you have a mental health issue?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused		
18.	Have you ever been prescribed medications for a mental health condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	If yes, do you know for what?	
19.	Other medication:	Are you taking your medication? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused		
20.	Do you ever see or hear things the other people don't see or hear?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	Interviewer Comments:	
21.	History of harm to self or others:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	Have you been admitted to a psychiatric hospital in the past two (2) years? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	Have you ever been hospitalized for psychiatric problems? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
22.	Optional narrative:			

HOMELESS OUTREACH WORKER (HOW) SCREENING TOOL

ALCOHOL AND DRUGS			
23. Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	If yes, what kind?	Frequency:
24. Do you currently use recreational drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	If yes, what kind?	Frequency:
25. <i>Optional narrative:</i>			

RESIDENCE HISTORY		
26. Residence night before first contact:	Time Homeless:	Is this your first time experiencing homelessness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
27. Cause of homelessness:		
28. Barriers to locating, securing, and maintaining stable housing:		
29. Describe your last living situation (household configuration):		
30. <i>Optional narrative:</i>		

LEGAL			
31. Arrested/charged/convicted/registered for:	Arson: <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex crimes: <input type="checkbox"/> Yes <input type="checkbox"/> No	
32. Are you on probation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you on parole? <input type="checkbox"/> Yes <input type="checkbox"/> No		
33. Contacts, if applicable:			
34. Pending court dates:			
35. <i>Optional narrative:</i>			

Completed by: _____
Print Name

_____ Date

_____ Title

_____ Phone Number