Administration

Interviewer's Name	**Agency**	☐ Team ☐ Staff ☐ Volunteer
_____	_____	
Survey Date	**Survey Time**	**Survey Location**
DD/MM/YYYY ____/____/_____	__ __ : __ __ AM/PM	_____

Opening Script

Every assessor in your community regardless of organization completing the VI-SPDAT should use the same introductory script. In that script you should highlight the following information:

- the name of the assessor and their affiliation (organization that employs them, volunteer as part of a Point in Time Count, etc.)
- the purpose of the VI-SPDAT being completed
- that it usually takes less than 7 minutes to complete
- that only "Yes," "No," or one-word answers are being sought
- that any question can be skipped or refused
- where the information is going to be stored
- that if the participant does not understand a question or the assessor does not understand the question that clarification can be provided
- the importance of relaying accurate information to the assessor and not feeling that there is a correct or preferred answer that they need to provide, nor information they need to conceal

Basic Information

First Name	**Nickname**	**Last Name**
_____	_____	_____

In what language do you feel best able to express yourself? _____

Date of Birth	**Age**	**Social Security Number**	**Consent to participate**	
DD/MM/YYYY ____/____/_____	_____	_____	☐ Yes	☐ No

IF THE PERSON IS 60 YEARS OF AGE OR OLDER, THEN SCORE 1.

SCORE:

1 (800) 355-0420 info@orgcode.com www.orgcode.com

A. History of Housing and Homelessness

1. Where do you sleep most frequently? (check one)

☐ Shelters
☐ Transitional Housing
☐ Safe Haven
☐ **Outdoors**
☐ **Other (specify):** _____
☐ **Refused**

IF THE PERSON ANSWERS ANYTHING OTHER THAN "SHELTER", "TRANSITIONAL HOUSING", OR "SAFE HAVEN", THEN SCORE 1.	**SCORE:**

2. How long has it been since you lived in permanent stable housing? _____ ☐ Refused

3. In the last three years, how many times have you been homeless? _____ ☐ Refused

IF THE PERSON HAS EXPERIENCED 1 OR MORE CONSECUTIVE YEARS OF HOMELESSNESS, AND/OR 4+ EPISODES OF HOMELESSNESS, THEN SCORE 1.	**SCORE:**

B. Risks

4. In the past six months, how many times have you...

a) Received health care at an emergency department/room? ____ ☐ Refused

b) Taken an ambulance to the hospital? ____ ☐ Refused

c) Been hospitalized as an inpatient? ____ ☐ Refused

d) Used a crisis service, including sexual assault crisis, mental health crisis, family/intimate violence, distress centers and suicide prevention hotlines? ____ ☐ Refused

e) Talked to police because you witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told you that you must move along? ____ ☐ Refused

f) Stayed one or more nights in a holding cell, jail or prison, whether that was a short-term stay like the drunk tank, a longer stay for a more serious offence, or anything in between? ____ ☐ Refused

IF THE TOTAL NUMBER OF INTERACTIONS EQUALS 4 OR MORE, THEN SCORE 1 FOR **EMERGENCY SERVICE USE.**	**SCORE:**

5. Have you been attacked or beaten up since you've become homeless? ☐ **Y** ☐ N ☐ Refused

6. Have you threatened to or tried to harm yourself or anyone else in the last year? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **RISK OF HARM.**	**SCORE:**

7. Do you have any legal stuff going on right now that may result in you being locked up, having to pay fines, or that make it more difficult to rent a place to live? ☐ **Y** ☐ N ☐ Refused

IF "YES," THEN SCORE 1 FOR **LEGAL ISSUES.** **SCORE:**

8. Does anybody force or trick you to do things that you do not want to do? ☐ **Y** ☐ N ☐ Refused

9. Do you ever do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone you don't know, share a needle, or anything like that? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **RISK OF EXPLOITATION.** **SCORE:**

C. Socialization & Daily Functioning

10. Is there any person, past landlord, business, bookie, dealer, or government group like the IRS that thinks you owe them money? ☐ **Y** ☐ N ☐ Refused

11. Do you get any money from the government, a pension, an inheritance, working under the table, a regular job, or anything like that? ☐ Y ☐ **N** ☐ Refused

IF "YES" TO QUESTION 10 OR "NO" TO QUESTION 11, THEN SCORE 1 FOR **MONEY MANAGEMENT.** **SCORE:**

12. Do you have planned activities, other than just surviving, that make you feel happy and fulfilled? ☐ Y ☐ **N** ☐ Refused

IF "NO," THEN SCORE 1 FOR **MEANINGFUL DAILY ACTIVITY.** **SCORE:**

13. Are you currently able to take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water and other things like that? ☐ Y ☐ **N** ☐ Refused

IF "NO," THEN SCORE 1 FOR **SELF-CARE.** **SCORE:**

14. Is your current homelessness in any way caused by a relationship that broke down, an unhealthy or abusive relationship, or because family or friends caused you to become evicted? ☐ **Y** ☐ N ☐ Refused

IF "YES," THEN SCORE 1 FOR **SOCIAL RELATIONSHIPS.** **SCORE:**

D. Wellness

15. Have you ever had to leave an apartment, shelter program, or other place you were staying because of your physical health?	☐ **Y**	☐ N	☐ Refused
16. Do you have any chronic health issues with your liver, kidneys, stomach, lungs or heart?	☐ **Y**	☐ N	☐ Refused
17. If there was space available in a program that specifically assists people that live with HIV or AIDS, would that be of interest to you?	☐ **Y**	☐ N	☐ Refused
18. Do you have any physical disabilities that would limit the type of housing you could access, or would make it hard to live independently because you'd need help?	☐ **Y**	☐ N	☐ Refused
19. When you are sick or not feeling well, do you avoid getting help?	☐ **Y**	☐ N	☐ Refused
20. *FOR FEMALE RESPONDENTS ONLY:* Are you currently pregnant?	☐ **Y**	☐ N	☐ N/A or Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **PHYSICAL HEALTH.** **SCORE:**

21. Has your drinking or drug use led you to being kicked out of an apartment or program where you were staying in the past?	☐ **Y**	☐ N	☐ Refused
22. Will drinking or drug use make it difficult for you to stay housed or afford your housing?	☐ **Y**	☐ N	☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **SUBSTANCE USE.** **SCORE:**

23. Have you ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of:

a) A mental health issue or concern?	☐ **Y**	☐ N	☐ Refused
b) A past head injury?	☐ **Y**	☐ N	☐ Refused
c) A learning disability, developmental disability, or other impairment?	☐ **Y**	☐ N	☐ Refused
24. Do you have any mental health or brain issues that would make it hard for you to live independently because you'd need help?	☐ **Y**	☐ N	☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **MENTAL HEALTH.** **SCORE:**

IF THE RESPONENT SCORED 1 FOR **PHYSICAL HEALTH** AND 1 FOR **SUBSTANCE USE** AND 1 FOR **MENTAL HEALTH**, SCORE 1 FOR **TRI-MORBIDITY**. **SCORE:**

25. Are there any medications that a doctor said you should be taking that, for whatever reason, you are not taking? ☐ **Y** ☐ N ☐ Refused

26. Are there any medications like painkillers that you don't take the way the doctor prescribed or where you sell the medication? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR **MEDICATIONS.** **SCORE:**

27. *YES OR NO:* Has your current period of homelessness been caused by an experience of emotional, physical, psychological, sexual, or other type of abuse, or by any other trauma you have experienced? ☐ **Y** ☐ N ☐ Refused

IF "YES", SCORE 1 FOR **ABUSE AND TRAUMA.** **SCORE:**

Scoring Summary

DOMAIN	SUBTOTAL
PRE-SURVEY	/1
A. HISTORY OF HOUSING & HOMELESSNESS	/2
B. RISKS	/4
C. SOCIALIZATION & DAILY FUNCTIONS	/4
D. WELLNESS	/6
GRAND TOTAL:	/17

RESULTS	
Score:	**Recommendation:**
0-3:	no housing intervention
4-7:	an assessment for Rapid Re-Housing
8+:	an assessment for Permanent Supportive Housing/Housing First

Follow-Up Questions

On a regular day, where is it easiest to find you and what time of day is easiest to do so?	place: _____ time: ___ : ____ or Morning/Afternoon/Evening/Night
Is there a phone number and/or email where someone can safely get in touch with you or leave you a message?	phone: (____) _____ - _____ email: _____
Ok, now I'd like to take your picture so that it is easier to find you and confirm your identity in the future. May I do so?	☐ Yes ☐ No ☐ Refused

Local Question (Unscored)

Since you moved away from your parents or foster parents, how many years in your entire life have you lived on the streets or in emergency shelter? **Years:**_____

Have you ever served in the U.S. Military? ☐ **Yes** ☐ **No** ☐ **Refused**
If Yes, complete SF 180

1 (800) 355-0420 info@orgcode.com www.orgcode.com

MARIN COUNTY HOMELESS MANAGEMENT INFORMATION SYSTEM (HMIS)

Client Consent for Data Collection and Release of Information

WHAT IS THE HMIS?

The HMIS is a data system that stores information about homelessness and housing services and programs. The purpose of the HMIS is for homeless provider agencies to record information about clients that they serve. This information helps the provider agencies plan for and provide services to clients and to meet requirements of funders such as the U.S. Department of Housing and Urban Development (HUD). HMIS also allows agencies to improve services that support people who are homeless by allowing authorized staff to share client information with the permission of the client. Marin County Health & Human Services manage the HMIS for Marin County.

WHAT IS THE PURPOSE OF THIS FORM?

With this form, you can give permission to have information about you collected and shared with the different Partner Agencies that provide housing and services in Marin County. A current list of Partner Agencies is at http://marin.clarityhs.help. At this time, the Partner Agencies include:

Adopt A Family of Marin
Buckelew
Center Point
Community Action Marin
Downtown Streets Team
Gilead House
Homeward Bound of Marin
Homeless Outreach Team (HOT)
Marin City Health & Wellness
Marin County Behavioral Health & Recovery Services
Marin County Health & Human Services
Marin Housing Authority
St. Vincent de Paul Society
Side by Side Youth (formerly Sunny Hills)
Ritter Center
U.S. Department of Veterans Affairs (VA)

BY SIGNING THIS FORM, I AUTHORIZE Marin County and Partner Agencies to share my information entered into the HMIS. The HMIS information shared will be used to help provide housing and services, which includes care coordination, counseling, food, utility assistance, and to evaluate and improve the quality of housing and service programs. I understand that the Partner Agencies may change over time and that I may find a current list at http://marin.clarityhs.help.

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- The information to be collected and shared includes:
  - Name, birthday, gender, race, ethnicity, social security number, contact information, veteran status
  - Basic information on self-reported disabling conditions caused by medical, mental health, substance use or developmental factors, including self-reported HIV/AIDS status.
  - Housing Information
  - Employment, income, insurance and benefits information
  - Services provided by Partner Agencies
  - My answers to assessment questions, including the VI-SPDAT questionnaire
  - My photograph or other likeness (if included)

- I may refuse to provide any of this information. If I refuse, I will not lose any benefits or services.
- I may refuse to sign this Consent. If I refuse, I will not lose any benefits or services.
- Marin County and Partner Agencies will keep my HMIS information private using strict privacy policies. I have the right to review the privacy policies that govern this information.
- Marin County Health & Human Services and BitFocus use passwords and encryption technology to ensure that information in the system is safe, and each HMIS User and Partner Agency has signed an agreement to maintain the security and confidentiality of HMIS data. However, there is always a small risk of a security breach, and someone might obtain my information and use it inappropriately. Marin County and Partner Agencies are required to alert me if they know of a breach.
- If I have questions about my HMIS information, my rights regarding that HMIS information, or am concerned that my information has been misused, I can contact my HMIS systems administrator at [contact info].
- I can receive a copy of this Consent and the Client Information Sheet.
- This Consent will expire 3 years from my last HMIS recorded activity.
- I may revoke this Consent at any time by sending a written request to [email] or by contacting the Partner Agency that is providing this Release of Information.
- My HMIS information may be shared to coordinate referral and placement for housing and services.
- My HMIS information may be further shared by the Partner Agencies to other agencies if needed for care coordination, counseling, food, utility assistance, and other services.
- My HMIS information may be included in reports for auditors or funders who review the work of the Partner Agencies, including HUD, the Department of Veteran Affairs, the Marin County Department of Health and Human Services, and the California Department of Housing and Community Development. I understand that the list of auditors and funders may change over time. My identity will not be shared in these reports.
- My HMIS information may be used for research; however, my identity will remain private.

____ I have been offered and declined a copy of this form

____ I have received a copy of this form

SIGNATURE: Date:

_____ _____

Printed Name:

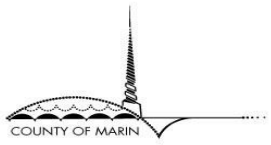
_____

FOR AGENCY USE ONLY:

Client Opted Out/Refused Consent: _____ (Staff/Agency Initials)

_____ _____

Witness Staff & Agency Date



Marin County - Whole Person Care Program
Consent to Release and/or Exchange *Non-SUD* Patient Records

Participant Name *(print neatly):* _____

Date of Birth _____ Gender: _____

Month/day/year

Medi-Cal CIN *(Include if known)* _____

Completion of this document authorizes the use and disclosure of protected health and/or eligibility information about you. This excludes the release of any Substance Use Disorder (SUD) records subject to 42 C.F.R part 2. Failure to provide all information requested may invalidate this consent.

Who May Use, Disclose or Share My Information:

In order for Whole Person Care (WPC) Participating Entities to identify and coordinate services, it is essential that we have your permission to share and exchange relevant information with your care providers and other providers of services available to you. The following is a comprehensive list of those agencies who participate in the WPC Data Sharing Program. Sharing any of your information with any of these agencies will only be on a need to know basis and only for the coordination of your care or services.

I hereby authorize the release of the below-identified information by, and the exchange of the below-identified information between, all Marin County Whole Person Care project agencies, entities, and facilities, which may include the following: Marin County HHS **(Excludes Substance Use Disorder Records subject to 42 CFR Part 2),** Marin County District Attorney, County of Marin Probation Department, County of Marin Public Defender, Bright Heart Health, Buckelew Programs, Center Point **(Excludes Substance Use Disorder Records subject to 42 CFR Part 2**), Central Marin Police Authority, City of Novato, City of San Rafael, Coastal Health Alliance, Community Action Marin, Downtown Streets Team, Healthy Marin Partnership, Homeward Bound, Kaiser Permanente San Rafael, LifeLong Medical, Marin City Health and Wellness Center, Marin Community Clinics, Marin County Sheriff's Office, Marin General Hospital, Marin Health Gateway, Marin Housing Authority, Marin Treatment Center (**Excludes Substance Use Disorder Records subject to 42 CFR Part 2**), North Marin Community Services, Opportunity Village, Partnership Health Plan of CA, Ritter Center, Senior Access, St. Vincent de Paul Society, Sunny Hills Services, The Spahr Center, US Department of Veterans Affairs, Whistlestop.

A complete and current list of participants, individuals and entities has been provided to me and is available from the Whole Person Care Webpage: https://www.marinhhs.org/whole-person-care

The Purpose(s) of Disclosure(s)/Sharing:
The purpose of this consent is to enable staff and members of the authorized entities listed above to coordinate, collaborate, and assess appropriate medical, housing and/or supportive services related to obtaining housing and improving care coordination (including but not limited to outreach, case management, emergency shelter, employment services, benefits assistance, medical and/or behavioral health services, life skills classes, and housing search assistance). I understand that Information will not be shared for any other purpose unless required by law or specifically authorized by me.

My Rights

- I may refuse to sign this consent. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits otherwise available to me.
- I have a right to receive a copy of this consent.
- I may revoke (take back) this consent at any time. To do so I must submit my revocation request in writing to the following address:

Compliance Program - Department of Health and Human Services,
20 N. San Pedro Rd, San Rafael, CA 94903
Or e-mail: HHSCompliance@marincounty.org

- My revocation will take effect upon receipt, except to the extent that others have already acted in reliance upon this authorization.

Re-Disclosure:

I understand that health and personal information disclosed pursuant to this Authorization could be re-disclosed by the recipient. Such re-disclosure is, in some cases, not protected by California law and may no longer be protected by federal confidentiality law such as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164. I understand mental health records are subject to Welfare & Institutions Code 5328 and the CA Confidentiality of Medical Information Act, and cannot be re-disclosed without my written consent unless otherwise provided for or required by law.

What Will be Disclosed or Exchanged: This is a full-disclosure authorization of my health and/or eligibility information, unless I specify any limitations below. Information which may include medical, surgical, communicable diseases, labs, medications, eligibility for state benefits, and any other personal information which may assist the

above agencies in carrying out the purpose(s) indicated above. Mental health and HIV test results are specifically protected by Federal or State law and require my explicit consent to release these records, if any, as indicated below:

Client Cell Phone (optional):
I agree to receiving calls or texts (to establish contact with program staff) at this number: **( )** ____ **-** _____

Mental health treatment records _____ (Sign to Permit)

Results of HIV Tests _____ (Sign to Permit)

Limitations: The following types of information may **not** be used, disclosed or shared (e.g. lab test results, prescription information, etc.):

_____

_____

_____

Additional Parties: I provide permission to share and exchange relevant information with the following additional individuals or organizations:

_____

_____

Expiration:
This authorization expires on (date): _____,
or (event): example: I am no longer enrolled in the Whole Person Care Program.

If I do not write in a date or event, this authorization will remain in effect for three (3) years from the date of my signature.

Signature _____ **Today's** date _____
Participant/Legal Representative

ROI collected by (name, agency): _____

If not signed by individual (enrollee), name and relationship of Legal Representative:
_____

Witness Signature (optional)_____

Witness Printed Name _____ Today's Date_____

- -

For Office Use Only:

Revoked by (name) ___________________________________ Date ____________

Revocation received by: (name) ____

Date informed WPC project: _________________