



## **Coordinated Entry System**

### **For Families**

VI-FSPDAT

2026

# CES for Families: VI-FSPDAT

HOH Name / HMIS ID: \_\_\_\_\_

## **VI-FSPDAT**- All fields required unless otherwise noted

HoH Name/ID: \_\_\_\_\_

Assessment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Family Response Team: \_\_\_\_\_

Family Solutions Center: \_\_\_\_\_

Assessment Type (circle which one): Phone / Virtual / In Person

Assessment Level (circle which one): Crisis Needs Assessment / Housing Need Assessment

### **Introductory Script – Must be read prior to administering the tool**

Hello! My name is \_\_\_\_\_ and I am with a group called \_\_\_\_\_ (organization name). I have a survey I would like to complete with you.

- Most questions only require a “yes,” “no” or other one-word answer. If you have more to share about an answer, I’d be happy to discuss that after the survey, but let’s finish the survey first. The survey should only take about 7 minutes to complete if we stick to “yes” or “no” responses.
- This is not a housing application, but the answers will help us understand your health and housing needs and the needs of our community, and may help us make better referrals for you in the future. It is important that you provide accurate information so please do not feel that there is a correct or preferred answer that you need to provide or conceal.
- The questions are not being asked in order to make any personal judgments about you. Some questions are personal in nature, but again, every question is designed to help us help you. You can skip or refuse any question that you don’t feel comfortable answering, but the more questions you’re willing to answer, the better.
- This survey is for all families who are homeless – not just people with a certain type of need.
- There is no need to take this survey twice, but from time to time we may want to update it with you, to make sure the information is accurate.
- If there is a question which you do not understand, please let me know and I would be happy to provide clarification.

### **Immediate Safety Assessment**

**Please note: All questions shaded in dark gray are REQUIRED. All questions in light gray are SOFT REQUIRED. All questions not shaded at all (white) are not required. All questions answered with a \* or \*\* that are followed by a follow-up questions are REQUIRED as well. Please read all parts of the document fully and thoroughly and follow the instructions. Follow this rule throughout the entire survey.**

**Instructions for surveyor (DO NOT READ ALOUD):** Due to the confidential nature of the following questions, we ask that you try to secure a private space where the **respondent is unaccompanied**. Regardless of the outcome, please remain neutral in your response and reserve judgment and unsolicited advice.

|                                                                                                           |                                                               |                                                                                                                                                      |
|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Are you seeking services today because you are concerned about your immediate safety related to abuse? | <input type="checkbox"/> No<br><input type="checkbox"/> Yes   | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer                                                |
| 2. If you experienced domestic or intimate partner violence, was this within the past month?              | <input type="checkbox"/> No<br><input type="checkbox"/> Yes** | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer<br><input type="checkbox"/> Data not collected |
| 3. Are you currently fleeing because you are in danger?                                                   | <input type="checkbox"/> No<br><input type="checkbox"/> Yes** | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer<br><input type="checkbox"/> Data not collected |

**If question #2 and #3 were both answered as “Yes” (\*\*), then participant should be referred to the LA County Domestic Violence Hotline 1-800-978-3600. Participant has the choice to continue receiving services through CES.**

## Pre-Survey

|                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Are either head of household 60 years or older (Auto calculated in Clarity)?                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Yes <input type="checkbox"/> Client prefers not to answer |
| Is there a secondary Head of Household?                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> No<br><input type="checkbox"/> Yes**                                                                                                  |
| If answered "Yes" (**), the following are required:                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                |
| Second HoH full name                                                                                                                             | _____                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                |
| Second HoH date of birth                                                                                                                         | ____/____/____                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                |
| 1. Total number of children under age 18 that are currently with you or that you have reason to believe will be joining you when you get housed? |                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> Prefers not to answer                                                                                                                 |
| Child 1 Full Name: _____                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                    | DOB: ____/____/____                                                                                                                                            |
| Child 2 Full Name: _____                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                    | DOB: ____/____/____                                                                                                                                            |
| Child 3 Full Name: _____                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                    | DOB: ____/____/____                                                                                                                                            |
| Child 4 Full Name: _____                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                    | DOB: ____/____/____                                                                                                                                            |
| Child 5 Full Name: _____                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                    | DOB: ____/____/____                                                                                                                                            |
| Child 6 Full Name: _____                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                    | DOB: ____/____/____                                                                                                                                            |
| Child 7 Full Name: _____                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                    | DOB: ____/____/____                                                                                                                                            |
| Child 8 Full Name: _____                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                    | DOB: ____/____/____                                                                                                                                            |
| Child 9 Full Name: _____                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                    | DOB: ____/____/____                                                                                                                                            |
| Child 10 Full Name: _____                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                    | DOB: ____/____/____                                                                                                                                            |
| 2. <i>If household includes a female:</i> Is any member of the family currently pregnant?                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Yes <input type="checkbox"/> Client prefers not to answer |
| SCORING                                                                                                                                          | Either head of household 60 years or older, score 1.                                                                                                                                                                                                                                                                                                                                                               | <b>SCORE:</b> _____                                                                                                                                            |
|                                                                                                                                                  | Score 1 for <b>FAMILY SIZE</b> if the family consists of:<br>A Single parent with: <ul style="list-style-type: none"> <li>• 2+ children, and/or</li> <li>• Child aged 11 or younger, and/or</li> <li>• Current pregnancy</li> </ul> <b>OR</b><br>Two parents with: <ul style="list-style-type: none"> <li>• 3+ children, and/or</li> <li>• Child aged 6 or younger, and/or</li> <li>• Current pregnancy</li> </ul> | <b>SCORE:</b> _____                                                                                                                                            |

## A. History of Housing and Homelessness

|                                                                      |                                                                                                                                  |                                                                                                                                                                                                                                              |                                                                                                                                                             |
|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 4. Where do you sleep most frequently?                               |                                                                                                                                  | <input type="checkbox"/> Shelters<br><input type="checkbox"/> Transitional Housing<br><input type="checkbox"/> Safe Haven<br><input type="checkbox"/> Couch Surfing*<br><input type="checkbox"/> Outdoors*<br><input type="checkbox"/> Cars* | <input type="checkbox"/> Other* (specify: _____)<br><input type="checkbox"/> Client doesn't know*<br><input type="checkbox"/> Client prefers not to answer* |
|                                                                      |                                                                                                                                  | <b>If the family answers anything other than "Shelters", "Transitional Housing", or "Safe Haven", then score 1.</b>                                                                                                                          |                                                                                                                                                             |
|                                                                      |                                                                                                                                  | <b>Score:</b>                                                                                                                                                                                                                                |                                                                                                                                                             |
| 5. How long has it been since you lived in permanent stable housing? | <input type="checkbox"/> Less than a week<br><input type="checkbox"/> 1 week – 3 months<br><input type="checkbox"/> 3 – 6 months | <input type="checkbox"/> 6 months to 1 year<br><input type="checkbox"/> 1 – 2 years<br><input type="checkbox"/> 2 years or more                                                                                                              | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer                                                       |
| 6. In the last three years, how many times have you been homeless?   | <input type="checkbox"/> 0 times<br><input type="checkbox"/> 1 time<br><input type="checkbox"/> 2 times                          | <input type="checkbox"/> 3 times<br><input type="checkbox"/> 4 times<br><input type="checkbox"/> 5 or more times                                                                                                                             | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer                                                       |
|                                                                      |                                                                                                                                  | <b>If the family has experienced 1 or more consecutive years of homelessness, and/or 4+ episodes of homelessness, then score 1.</b>                                                                                                          |                                                                                                                                                             |
|                                                                      |                                                                                                                                  | <b>Score:</b>                                                                                                                                                                                                                                |                                                                                                                                                             |

## B. Risks

|                                                                                                                                                                                            |                                                                                                         |                                                                                                                  |                                                                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 7. In the past six months, how many times have you or anyone in your family...                                                                                                             |                                                                                                         |                                                                                                                  |                                                                                                       |
| 7a. Received health care at an emergency department / room?                                                                                                                                | <input type="checkbox"/> 0 times<br><input type="checkbox"/> 1 time<br><input type="checkbox"/> 2 times | <input type="checkbox"/> 3 times<br><input type="checkbox"/> 4 times<br><input type="checkbox"/> 5 or more times | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer |
| 7b. Taken an ambulance to the hospital?                                                                                                                                                    | <input type="checkbox"/> 0 times<br><input type="checkbox"/> 1 time<br><input type="checkbox"/> 2 times | <input type="checkbox"/> 3 times<br><input type="checkbox"/> 4 times<br><input type="checkbox"/> 5 or more times | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer |
| 7c. Been hospitalized as an in-patient?                                                                                                                                                    | <input type="checkbox"/> 0 times<br><input type="checkbox"/> 1 time<br><input type="checkbox"/> 2 times | <input type="checkbox"/> 3 times<br><input type="checkbox"/> 4 times<br><input type="checkbox"/> 5 or more times | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer |
| 7d. Used a crisis service, including sexual assault crisis, mental health crisis, family/intimate violence, distress centers and suicide prevention hotlines?                              | <input type="checkbox"/> 0 times<br><input type="checkbox"/> 1 time<br><input type="checkbox"/> 2 times | <input type="checkbox"/> 3 times<br><input type="checkbox"/> 4 times<br><input type="checkbox"/> 5 or more times | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer |
| 7e. 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?             | <input type="checkbox"/> 0 times<br><input type="checkbox"/> 1 time<br><input type="checkbox"/> 2 times | <input type="checkbox"/> 3 times<br><input type="checkbox"/> 4 times<br><input type="checkbox"/> 5 or more times | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer |
| 7f. 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? | <input type="checkbox"/> 0 times<br><input type="checkbox"/> 1 time<br><input type="checkbox"/> 2 times | <input type="checkbox"/> 3 times<br><input type="checkbox"/> 4 times<br><input type="checkbox"/> 5 or more times | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer |
|                                                                                                                                                                                            |                                                                                                         | <b>If the total number of interactions equals 4 or more, then score 1 for Emergency Service Use.</b>             |                                                                                                       |
|                                                                                                                                                                                            |                                                                                                         | <b>Score:</b>                                                                                                    |                                                                                                       |
| 8. Have you or anyone in your family been attacked or beaten up since you've become homeless?                                                                                              | <input type="checkbox"/> No<br><input type="checkbox"/> Yes**                                           | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer            |                                                                                                       |
| 9. Have you or anyone in your family threatened to or tried to harm yourself or anyone else in the last year?                                                                              | <input type="checkbox"/> No<br><input type="checkbox"/> Yes**                                           | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer            |                                                                                                       |

|                                                                                                                                                                                                                                           |                                                                                                                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>If "Yes" (**) to any of the above, then score 1 for <i>Risk of Harm</i>. <span style="float: right;">Score:</span></p>                                                                                                                 |                                                                                                                                                                                               |
| <p>10. Do you or any member of the family 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?</p>                                | <p> <input type="checkbox"/> No      <input type="checkbox"/> Client doesn't know<br/> <input type="checkbox"/> Yes**      <input type="checkbox"/> Client prefers not to answer         </p> |
| <p>If "Yes" (**), then score 1 for <i>Legal Issues</i>. <span style="float: right;">Score:</span></p>                                                                                                                                     |                                                                                                                                                                                               |
| <p>11. Does anybody force or trick you or anyone in your family to do things that you do not want to do?</p>                                                                                                                              | <p> <input type="checkbox"/> No      <input type="checkbox"/> Client doesn't know<br/> <input type="checkbox"/> Yes**      <input type="checkbox"/> Client prefers not to answer         </p> |
| <p>12. Do you or anyone in your family 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?</p> | <p> <input type="checkbox"/> No      <input type="checkbox"/> Client doesn't know<br/> <input type="checkbox"/> Yes**      <input type="checkbox"/> Client prefers not to answer         </p> |
| <p>If "Yes" (**) to any of the above, then score 1 for <i>Risk of Exploitation</i>. <span style="float: right;">Score:</span></p>                                                                                                         |                                                                                                                                                                                               |

## C. Socialization & Daily Functioning

|                                                                                                                                                                                                        |                                                                                                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>13. Is there any person, past landlord, business, bookie, dealer, or government group like the IRS that thinks you or anyone in your family owe them money?</p>                                     | <p> <input type="checkbox"/> No      <input type="checkbox"/> Client doesn't know<br/> <input type="checkbox"/> Yes**      <input type="checkbox"/> Client prefers not to answer         </p> |
| <p>14. Do you or anyone in your family get any money from the government, a pension, an inheritance, working under the table, a regular job, or anything like that?</p>                                | <p> <input type="checkbox"/> No*      <input type="checkbox"/> Client doesn't know<br/> <input type="checkbox"/> Yes      <input type="checkbox"/> Client prefers not to answer         </p>  |
| <p>If "Yes" (**) to question 13 or "No" (*) to question 14, then score 1 for <i>Money Management</i>. <span style="float: right;">Score:</span></p>                                                    |                                                                                                                                                                                               |
| <p>15. Does everyone in your family have planned activities, other than just surviving, that make you feel happy and fulfilled?</p>                                                                    | <p> <input type="checkbox"/> No*      <input type="checkbox"/> Client doesn't know<br/> <input type="checkbox"/> Yes      <input type="checkbox"/> Client prefers not to answer         </p>  |
| <p>If "No" (*), then score 1 for <i>Meaningful Daily Activity</i>. <span style="float: right;">Score:</span></p>                                                                                       |                                                                                                                                                                                               |
| <p>16. Is everyone in your family 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?</p>            | <p> <input type="checkbox"/> No*      <input type="checkbox"/> Client doesn't know<br/> <input type="checkbox"/> Yes      <input type="checkbox"/> Client prefers not to answer         </p>  |
| <p>If "No" (*), then score 1 for <i>Self-Care</i>. <span style="float: right;">Score:</span></p>                                                                                                       |                                                                                                                                                                                               |
| <p>17. Is your family's 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?</p> | <p> <input type="checkbox"/> No      <input type="checkbox"/> Client doesn't know<br/> <input type="checkbox"/> Yes**      <input type="checkbox"/> Client prefers not to answer         </p> |
| <p>If "Yes" (**), then score 1 for <i>Social Relationships</i>. <span style="float: right;">Score:</span></p>                                                                                          |                                                                                                                                                                                               |

## D. Wellness

|                                                                                                                                                                                                                         |                                |                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-------------------------------------------------------|
| 18. Has your family ever had to leave an apartment, shelter program, or other place you were staying because of the physical health of you or anyone in your family?                                                    | <input type="checkbox"/> No    | <input type="checkbox"/> Client doesn't know          |
|                                                                                                                                                                                                                         | <input type="checkbox"/> Yes** | <input type="checkbox"/> Client prefers not to answer |
| 19. Do you or anyone in your family have any chronic health issues with your liver, kidneys, stomach, lungs or heart?                                                                                                   | <input type="checkbox"/> No    | <input type="checkbox"/> Client doesn't know          |
|                                                                                                                                                                                                                         | <input type="checkbox"/> Yes** | <input type="checkbox"/> Client prefers not to answer |
| 20. If there was space available in a program, housing, or resources that specifically assists people that live with HIV or AIDS, would that be of interest to you or anyone in your family?                            | <input type="checkbox"/> No    | <input type="checkbox"/> Client doesn't know          |
|                                                                                                                                                                                                                         | <input type="checkbox"/> Yes** | <input type="checkbox"/> Client prefers not to answer |
| 21. Does anyone in your family 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?                               | <input type="checkbox"/> No    | <input type="checkbox"/> Client doesn't know          |
|                                                                                                                                                                                                                         | <input type="checkbox"/> Yes** | <input type="checkbox"/> Client prefers not to answer |
| 22. When someone in your family is sick or not feeling well, does your family avoid getting medical help?                                                                                                               | <input type="checkbox"/> No    | <input type="checkbox"/> Client doesn't know          |
|                                                                                                                                                                                                                         | <input type="checkbox"/> Yes** | <input type="checkbox"/> Client prefers not to answer |
| <b>If "Yes" (**) to any of the above, then score 1 for <i>Physical Health</i>.      Score:</b>                                                                                                                          |                                |                                                       |
| 24. Has your drinking or drug use by you or anyone in your family led your family to being kicked out of an apartment or program where you were staying in the past?                                                    | <input type="checkbox"/> No    | <input type="checkbox"/> Client doesn't know          |
|                                                                                                                                                                                                                         | <input type="checkbox"/> Yes** | <input type="checkbox"/> Client prefers not to answer |
| 25. Will drinking or drug use make it difficult for your family to stay housed or afford your housing?                                                                                                                  | <input type="checkbox"/> No    | <input type="checkbox"/> Client doesn't know          |
|                                                                                                                                                                                                                         | <input type="checkbox"/> Yes** | <input type="checkbox"/> Client prefers not to answer |
| <b>If "Yes" (**) to any of the above, then score 1 for <i>Substance Use</i>.      Score:</b>                                                                                                                            |                                |                                                       |
| 26. Has your family ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of:                                                         |                                |                                                       |
| 26a. A mental health disorder or concern?                                                                                                                                                                               | <input type="checkbox"/> No    | <input type="checkbox"/> Client doesn't know          |
|                                                                                                                                                                                                                         | <input type="checkbox"/> Yes** | <input type="checkbox"/> Client prefers not to answer |
| 26b. A past head injury?                                                                                                                                                                                                | <input type="checkbox"/> No    | <input type="checkbox"/> Client doesn't know          |
|                                                                                                                                                                                                                         | <input type="checkbox"/> Yes** | <input type="checkbox"/> Client prefers not to answer |
| 26c. A learning disability, developmental disability, or other impairment?                                                                                                                                              | <input type="checkbox"/> No    | <input type="checkbox"/> Client doesn't know          |
|                                                                                                                                                                                                                         | <input type="checkbox"/> Yes** | <input type="checkbox"/> Client prefers not to answer |
| 27. Do you or anyone in your family have any mental health or brain issues that would make it hard for your family to live independently because you'd need help?                                                       | <input type="checkbox"/> No    | <input type="checkbox"/> Client doesn't know          |
|                                                                                                                                                                                                                         | <input type="checkbox"/> Yes** | <input type="checkbox"/> Client prefers not to answer |
| Does any single member of your household have a medical condition, mental health concerns, and experience with problematic substance use?                                                                               | <input type="checkbox"/> No    | <input type="checkbox"/> Client doesn't know          |
|                                                                                                                                                                                                                         | <input type="checkbox"/> Yes** | <input type="checkbox"/> Client prefers not to answer |
| <b>If "Yes" (**) to any of the above, then score 1 for <i>Mental Health</i>.      Score:</b>                                                                                                                            |                                |                                                       |
| <b>If the respondent scored 1 for <i>Physical Health</i> and 1 for <i>Substance Use</i> and 1 for <i>Mental Health</i>, score 1 for <i>Tri-Morbidity</i>.      Score:</b>                                               |                                |                                                       |
| 28. Are there any medications that a doctor said you or anyone in your family should be taking that, for whatever reason, they are not taking?                                                                          | <input type="checkbox"/> No    | <input type="checkbox"/> Client doesn't know          |
|                                                                                                                                                                                                                         | <input type="checkbox"/> Yes** | <input type="checkbox"/> Client prefers not to answer |
| 29. Are there any medications like painkillers that you or anyone in your family don't take the way the doctor prescribed or where they sell the medication?                                                            | <input type="checkbox"/> No    | <input type="checkbox"/> Client doesn't know          |
|                                                                                                                                                                                                                         | <input type="checkbox"/> Yes** | <input type="checkbox"/> Client prefers not to answer |
| <b>If "Yes" (**) to any of the above, then score 1 for <i>Medications</i>.      Score:</b>                                                                                                                              |                                |                                                       |
| 30. <b>YES OR NO:</b> Has your family's 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? | <input type="checkbox"/> No    | <input type="checkbox"/> Client doesn't know          |
|                                                                                                                                                                                                                         | <input type="checkbox"/> Yes** | <input type="checkbox"/> Client prefers not to answer |

If “Yes” (\*\*), then score 1 for *Abuse and Trauma*.

Score:

## E. Family Unit

|                                                                                                                                                                                                                                                                                           |                                                               |                                                                                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| 31. Are there any children that have been removed from the family by a child protection service within the last 180 days?                                                                                                                                                                 | <input type="checkbox"/> No<br><input type="checkbox"/> Yes** | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer        |
| If “yes” (**), do you have an open case with DCFS?                                                                                                                                                                                                                                        | <input type="checkbox"/> No<br><input type="checkbox"/> Yes   |                                                                                                              |
| 32. Do you have any family legal issues that are being resolved in court or need to be resolved in court that would impact your housing or who may live within your housing?                                                                                                              | <input type="checkbox"/> No<br><input type="checkbox"/> Yes** | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer        |
| If “Yes” (**), then score 1 for <i>Abuse and Trauma</i> .                                                                                                                                                                                                                                 |                                                               | Score:                                                                                                       |
| 33. In the last 180 days have any children lived with family or friends because of your homelessness or housing situation?                                                                                                                                                                | <input type="checkbox"/> No<br><input type="checkbox"/> Yes** | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer        |
| 34. Has any child in the family experienced abuse or trauma in the last 180 days?                                                                                                                                                                                                         | <input type="checkbox"/> No<br><input type="checkbox"/> Yes** | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer        |
| 35. <i>If there are school-aged children:</i> Do your children attend school more often than not each week?                                                                                                                                                                               | <input type="checkbox"/> No<br><input type="checkbox"/> Yes** | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer or N/A |
| If “Yes” (**), then score 1 for <i>Abuse and Trauma</i> .                                                                                                                                                                                                                                 |                                                               | Score:                                                                                                       |
| 36. Have the members of your family changed in the last 180 days, due to things like divorce, your kids coming back to live with you, someone leaving for military service or incarceration, a relative moving in, or anything like that?                                                 | <input type="checkbox"/> No<br><input type="checkbox"/> Yes** | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer        |
| 37. Do you anticipate any other adults or children coming to live with you in the next 180 days?                                                                                                                                                                                          | <input type="checkbox"/> No<br><input type="checkbox"/> Yes** | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer        |
| If “Yes” (**), then score 1 for <i>Abuse and Trauma</i> .                                                                                                                                                                                                                                 |                                                               | Score:                                                                                                       |
| 38. Do you have two or more planned activities each week as a family such as outings to the park, going to the library, visiting other family, watching a family movie, or anything like that?                                                                                            | <input type="checkbox"/> No**<br><input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer        |
| 39. After school, or on weekends or days when there isn't school, is the total time children spend each day where there is no interaction with you or another responsible adult...                                                                                                        |                                                               |                                                                                                              |
| a. 3 or more hours per day for children aged 13 or older?                                                                                                                                                                                                                                 | <input type="checkbox"/> No<br><input type="checkbox"/> Yes** | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer        |
| b. 2 or more hours per day for children aged 12 or younger?                                                                                                                                                                                                                               | <input type="checkbox"/> No<br><input type="checkbox"/> Yes** | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer        |
| 40. <i>If there are children both 12 and under and 13 and over:</i> Do your older kids spend 2 or more hours on a typical day helping their younger sibling(s) with things like getting ready for school, helping with homework, making them dinner, bathing them, or anything like that? | <input type="checkbox"/> No<br><input type="checkbox"/> Yes** | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer        |
| If “Yes” (**), then score 1 for <i>Abuse and Trauma</i> .                                                                                                                                                                                                                                 |                                                               | Score:                                                                                                       |

## Follow-Up

|                                                                                                                                         |                                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| <b>31. On a regular day...</b>                                                                                                          |                                                             |
| <b>31a.</b> Where is it easiest to find you?                                                                                            |                                                             |
| <b>31b.</b> What time of day is easiest to do so?                                                                                       |                                                             |
| <b>32. So that someone can safely get in touch with you or leave you a message...</b>                                                   |                                                             |
| <b>32a.</b> Phone number                                                                                                                | _____ -- _____ -- _____                                     |
| <b>32b.</b> Email address                                                                                                               |                                                             |
| <b>33. 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?</b> |                                                             |
|                                                                                                                                         | <input type="checkbox"/> No<br><input type="checkbox"/> Yes |

## Residency & Preferences

|                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>43. Where do you currently reside?</b>                                                                                                                       | Street 1:                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                 | Street 2:                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                 | City: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                 | State: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                 | ZIP: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>44. Have you called Long Beach/ Long Beach Unincorporated/ Santa Monica home within the last year (12 months)?</b>                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| If none of the cities on the list, what city have you called home within the last year?                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>44a. How many months have you stayed in that city/community?</b>                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>45. Is the region where you're currently residing where you're looking to be housed?</b><br>*SURVEYOR NOTE: location may be different from answer to Q44/44a | <input type="checkbox"/> Yes<br><input type="checkbox"/> No, I have another community in mind**                                                                                                                                                                                                                                                                                                                                                                      |
| If question #45 was answered as No (**), then the following question is <b>required</b> :                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>45a. What is the community you are looking to be housed in?</b><br>*SURVEYOR NOTE: Please check <b>ONLY ONE</b> SPA.                                         | <input type="checkbox"/> SPA 1 – Antelope Valley<br><input type="checkbox"/> SPA 2 – San Fernando Valley<br><input type="checkbox"/> SPA 3 – San Gabriel Valley<br><input type="checkbox"/> SPA 4 – Metro/Central LA<br><input type="checkbox"/> SPA 5 – West LA<br><input type="checkbox"/> SPA 6 – South LA<br><input type="checkbox"/> SPA 7 – Southeast / East LA<br><input type="checkbox"/> SPA 8 – South Bay<br><input type="checkbox"/> Outside of LA County |
| <b>46. Would you be interested in housing options such as shared housing, a room for rent, or sober living?</b>                                                 | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer                                                                                                                                                                                                                                                                                                 |

# CES for Families: VI-FSPDAT

HOH Name / HMIS ID: \_\_\_\_\_

|                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>47. Question for Participant:</b> Some housing units have disability-related features that make it easier for people with certain disabilities to live in that housing. If you or anyone in your household are to be placed in housing, would you need:                          | <input type="checkbox"/> Yes: a mobility unit<br><input type="checkbox"/> Yes: a hearing/vision unit<br><input type="checkbox"/> Yes: a mobility and hearing/vision unit<br><input type="checkbox"/> No                                                                                              |
| <b>48. Question for Staff:</b> Based on your observation, does this person/a person in this household appear to have:                                                                                                                                                               | <input type="checkbox"/> A mobility disability (uses a wheelchair, walker, or has difficulty walking)<br><input type="checkbox"/> A hearing disability (deaf or hard of hearing)<br><input type="checkbox"/> A visual disability (blind or low vision)<br><input type="checkbox"/> None of the above |
| <b>49. Question for Staff:</b> Based on your observation, might this person/a person in this household need assistance to communicate as effectively as someone without a disability (i.e. sign-language interpreter, large print or braille documents, hearing assistance device)? | <input type="checkbox"/> Yes*<br><input type="checkbox"/> No.                                                                                                                                                                                                                                        |
| If question #49 was answered as Yes (*), then the following question is <b>required</b> :                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                      |
| <b>49a. Ask:</b> Which assistance aides do they need?                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                      |

## **US Department of Veterans Affairs (VA), Department of Mental Health (DMH), and Department of Health Services (DHS)**

|                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|
| <b>41.</b> To the best of your knowledge, do you think you are VA Healthcare eligible?                                                                                                                                                     | <input type="checkbox"/> No<br><input type="checkbox"/> Yes**                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer                          |
| If "Yes" (**) to Veteran, administer VA release of information and refer to a veteran service provider to perform the "Supplemental – VA" assessment. Optional: complete the "Supplement – VA" assessment.                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                |
| <b>42.</b> Are you currently receiving or have you ever received treatment at a mental health program/clinic?                                                                                                                              | <input type="checkbox"/> No<br><input type="checkbox"/> Yes**                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer                          |
| <b>42a.</b> If "Yes" (**), what is the name of the program/clinic?                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                |
| <b>43.</b> Have you been a patient at any of the following DHS hospitals or at a DHS Health Center in the past 12 months?<br><i>(DHS stands for the LA County Department of Health Services)</i><br><br><i>Please check all that apply</i> | <input type="checkbox"/> Does not receive care at any DHS hospital or clinic<br><b>Hospitals</b><br><input type="checkbox"/> LAC + USC Med Center<br><input type="checkbox"/> Harbor UCLA Med Center<br><input type="checkbox"/> Olive View Med Center<br><input type="checkbox"/> Rancho Los Amigos<br><br><b>Multi-Service Ambulatory Care Centers</b><br><input type="checkbox"/> Martin Luther King, Jr. Outpatient Center<br><input type="checkbox"/> High Desert Regional Health Center<br><br><b>Comprehensive Health Centers</b><br><input type="checkbox"/> El Monte Comprehensive Health Center<br><input type="checkbox"/> Edward R. Roybal Comprehensive Health Center<br><input type="checkbox"/> H. Claude Hudson Comprehensive Health Center<br><input type="checkbox"/> Hubert H. Humphrey Comprehensive Health Center<br><input type="checkbox"/> Long Beach Comprehensive Health Center<br><input type="checkbox"/> Mid-Valley Comprehensive Health Center |                                                                                                                                |
|                                                                                                                                                                                                                                            | <b>Health Centers</b><br><input type="checkbox"/> Antelope Valley Health Center<br><input type="checkbox"/> Bellflower Health Center<br><input type="checkbox"/> Dollarhide Health Center<br><input type="checkbox"/> Glendale Health Center<br><input type="checkbox"/> La Puente Health Center<br><input type="checkbox"/> Lake Los Angeles Health Center<br><input type="checkbox"/> Little Rock Health Center<br><input type="checkbox"/> San Fernando Health Center<br><input type="checkbox"/> South Antelope Valley Health Center<br><input type="checkbox"/> Wilmington Health Center<br><br><b>Other</b><br><input type="checkbox"/> Other DHS clinic (Specify): _____                                                                                                                                                                                                                                                                                              |                                                                                                                                |
| If any hospital or center was answered for question #43, please answer this question if possible:                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                |
| <b>43a.</b> How many times have you accessed services at the DHS site(s) in the last 12 months?                                                                                                                                            | <input type="checkbox"/> 1<br><input type="checkbox"/> 2<br><input type="checkbox"/> 3<br><input type="checkbox"/> 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <input type="checkbox"/> 5<br><input type="checkbox"/> 6<br><input type="checkbox"/> 7<br><input type="checkbox"/> More than 7 |
|                                                                                                                                                                                                                                            | <input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client prefers not to answer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                |

**Disabling Condition** Required for all clients, all fields required except for VA and VASH Funded Programs

|                                                                  |                                                   |                                                   |                                                       |
|------------------------------------------------------------------|---------------------------------------------------|---------------------------------------------------|-------------------------------------------------------|
| 53. Do you think you might have any of the following conditions? | <input type="checkbox"/> Substance abuse disorder | <input type="checkbox"/> Developmental disability | <input type="checkbox"/> None of the above            |
|                                                                  | <input type="checkbox"/> Physical disability      | <input type="checkbox"/> Chronic physical illness | <input type="checkbox"/> Client doesn't know          |
|                                                                  | <input type="checkbox"/> Mental health disability | <input type="checkbox"/> HIV / AIDS               | <input type="checkbox"/> Client prefers not to answer |

**Housing History**

|                                                                                 |                              |                                                       |
|---------------------------------------------------------------------------------|------------------------------|-------------------------------------------------------|
| 54. Have you been evicted from a Public Housing Authority unit?                 | <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know          |
|                                                                                 | <input type="checkbox"/> No  | <input type="checkbox"/> Client prefers not to answer |
| 55. Have you ever been convicted of manufacturing or producing methamphetamine? | <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know          |
|                                                                                 | <input type="checkbox"/> No  | <input type="checkbox"/> Client prefers not to answer |
| 56. Are you required to register as a sex offender?                             | <input type="checkbox"/> Yes | <input type="checkbox"/> Client doesn't know          |
|                                                                                 | <input type="checkbox"/> No  | <input type="checkbox"/> Client prefers not to answer |

**Office Use Only**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                             |                                                                                                                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Potential Chronic Homelessness:</b> Is respondent potentially chronically homeless based on the following:</p> <p><input type="checkbox"/> History of Homelessness:<br/>Question #4 is 12 months or more, or<br/>Question #5 is 4 episodes or more</p> <p><input type="checkbox"/> Disability:<br/>Scored 1 point in Substance Use, or<br/>Scored 1 point in Mental Health, or<br/>At least one disability is identified in question #53, or<br/>Question #17, #18, #19, or #51 is Yes</p> <p><b>If the two boxes above are checked, then the respondent is potentially chronically homeless.</b></p> | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <p><b>Informs potential housing eligibility.</b></p>                                                                                                                                          |
| <p><b>Potential Veteran:</b> Did respondent answer "Yes" to Veteran?</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <p><b>Administer VA release of information and refer to a veteran service provider to perform the "Supplemental – VA" assessment. Optional: Perform the "Supplement – VA" assessment.</b></p> |
| <p><b>Domestic Violence:</b> Did respondent answer "yes" to question #2 and #3 from the Immediate Safety Assessment?</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <p><b>Refer the client to the LA County Domestic Violence Hotline: <u>1-800-978-3600</u></b></p> <p><b>Participant has the choice to continue receding services thought CES.</b></p>          |

# CES for Families: VI-FSPDAT

HOH Name / HMIS ID: \_\_\_\_\_

| Domain                               | Subtotal | Results                                                                                                                                                                                                        |
|--------------------------------------|----------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Pre-Survey                           | /2       | Score Result Recommendations:<br><br>0-3: No housing intervention. Provide referrals to other resources.<br><br>4-8: Referral for rapid rehousing program<br><br>9+: Referral for permanent supportive housing |
| A. History of Housing & Homelessness | /2       |                                                                                                                                                                                                                |
| B. Risks                             | /4       |                                                                                                                                                                                                                |
| C. Socialization & Daily Functioning | /4       |                                                                                                                                                                                                                |
| D. Wellness                          | /6       |                                                                                                                                                                                                                |
| E. Family Unit                       | /4       |                                                                                                                                                                                                                |
| Total Score                          | /22      |                                                                                                                                                                                                                |

Interviewer's Name: \_\_\_\_\_ Organization: \_\_\_\_\_

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

Date Survey Was Conducted: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

|                           |                 |
|---------------------------|-----------------|
| <b>Location Of Survey</b> | Street 1: _____ |
|                           | Street 2: _____ |
|                           | City: _____     |
|                           | State: _____    |
|                           | Zip: _____      |

## **ADDITIONAL SURVEYOR OBSERVATIONS (Notes)**

*May include observations about client or location, such as description of make-shift shelter, detailed description of vehicle (if respondent was residing in vehicle)*