***Continuum of Care for the City & County of Racine (WI-502)***



**Coordinated Entry System**

**Pre-Screen Form**

**Are you a victim/survivor of domestic or sexual violence?**  Yes |  No

**If yes, are you currently fleeing a domestic violence situation?**  Yes (*referral to a local DV agency needed)* | No

**Do you have a disability or need reasonable accommodations** for us to provide services to you, including filling out this form? (This question is voluntary and does not affect your eligibility for services.)

Yes, indicate needs below |  No

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| Do you need an interpreter?  Yes  No | Language: |  |

**Client Contact Information:**

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| Telephone No: |  | |  | Email: |  | |
| Social media handle: | |  | | | |

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| **On a regular day where is it easiest to find you?** |  | **What time:** |  |

**Are you formally a ward of the child welfare/foster care agency?**  Yes |  No

**Household members (**List everyone living in your household, related & unrelated.)

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| **Head of** | |  | |  | |  |  | |  | |  |  | |  |
| **Household**: | | **Last Name** | |  | | **First** |  | | **MI** | |  | **Date of Birth** | |  |
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|  | **Gender** | |  | | **Race** | | |  | | **Ethnicity** | |  | **Disability** |  |

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| **Household** |  | |  | |  |  | |  | |  |  | |  |
| **Member 02** | **Last Name** | |  | | **First** |  | | **MI** | |  | **Date of Birth** | |  |
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|  | **Gender** |  | | **Race** | | |  | | **Ethnicity** | |  | **Disability** |  |

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| **Household** |  | |  | |  |  | |  | |  |  | | |  |
| **Member 03** | **Last Name** | |  | | **First** |  | | **MI** | |  | **Date of Birth** | | |  |
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|  | **Gender** |  | | **Race** | | |  | | **Ethnicity** | | |  | **Disability** |  |

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| **Household** |  | |  | |  |  | |  | |  |  | | |  |
| **Member 04** | **Last Name** | |  | | **First** |  | | **MI** | |  | **Date of Birth** | | |  |
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|  | **Gender** |  | | **Race** | | |  | | **Ethnicity** | | |  | **Disability** |  |

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| **Household** |  | |  | |  |  | |  | |  |  | | |  |
| **Member 05** | **Last Name** | |  | | **First** |  | | **MI** | |  | **Date of Birth** | | |  |
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|  | **Gender** |  | | **Race** | | |  | | **Ethnicity** | | |  | **Disability** |  |

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| **Veteran Status** |  |  | **Veteran Benefit Status** |  |

**Living situation last night**

Emergency shelter, including hotel or motel paid for with emergency shelter voucher

Place not meant for habitation inclusive of “non-housing service site (outreach programs only)”

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| If **any of the above** 2 are checked, approximate date started and continued |  | \*\*Required for housing placement |

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| Staying or living in a family member’s room, apartment, or house | | | | | | | | Psychiatric hospital or other psychiatric facility center | | | | |
| Staying or living in a friend’s room, apartment, or house | | | | | | | | Hospital (non-psychiatric) | | | | |
| Rental by client, no housing subsidy | | | | | | | | Other | |  | | |
| Rental by client, with VASH housing subsidy | | | | | | | | Owned by client, no housing subsidy | | | | |
| Rental by client, with other (non- VASH) housing subsidy | | | | | | | | Owned by client, with housing subsidy | | | | |
| Jail, prison, or juvenile detention facility | | | | | | | | Foster care home or foster care group home | | | | |
| Transitional housing for homeless persons (including homeless youth) | | | | | | | | Substance abuse treatment facility or detox | | | | |
| Permanent housing for formerly homeless persons (such as SHP, S+C, or SRO Mod Rehab) | | | | | | | | Hotel or motel paid for without emergency shelter voucher | | | | |
| **Length of living situation in place marked above** | | | | |  |  | | | | | |
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| Number of times you have been on the Street, in an Emergency Shelter, on a motel voucher, or in a Safe Haven in the past | | | | | | | | | | | |
| three years including today: | | |  |  | | | | | | | |
|  | | | | | | | | | | | |
| Number of months homeless on the Street, in an Emergency Shelter, on a motel voucher, or in a Safe Haven in the past three | | | | | | | | | | | |
| years: |  |  | | | | | | | | |  |
| **If more than 12 months**, how many total months in the past 3 years? | | | | | | |  | |  | | |

Do you have an underlying health condition that puts you at higher risk for COVID-19?  Yes |  No

Are you or a household member an essential worker?  Yes |  No

**Do any of these experiences cause a barrier for you or your household getting housing?**

Criminal Background  Yes |  No

Prior Evictions  Yes |  No

Family with 5 people or more that cannot be housed in fewer than 3 bedrooms  Yes |  No

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| **Client Consent Section** | | | | | | | |
| Do you give consent that this agency may share information with other agencies such as, but not limited to, your situation, household demographics, and any questions asked during this assessment in order to provide referral to other services? | | | | | | | |
|  | | | | | | | |
| I understand that I can revoke this Authorization at any time, except for action already taken, by sending written notice | | | | | | | |
| to the authorized agent. This authorization expires | |  | from date of the signature below. | | | | |
|  | | | | | | | |
| I understand that the information contained on this form is provided voluntarily. The information is true and correct to the best of my knowledge.  \*\* I am aware that providing false information or not reporting pertinent information is fraud.  \*\* If I provide any false information, I understand that services may be denied.  \*\* I understand that completion of this form does not guarantee that I will receive assistance.  VERBAL | | | | | | | |
|  | | | | | | | |
| Signature of Applicant |  | | | |  | Date: |  |
|  |  | | | |  |  |  |
| Signature of Agency Rep: | | | |  |  | Date: |  |

**Staff use only:**

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| HOUSING STATUS | STAFF USE ONLY |
| Literally homeless | Unstably housed and at risk of losing housing (high-risk) |
| Imminently losing their housing | Stably housed |