Wraparound Housing at Clarke Square Screening Form

Care Coordinator Information

Name _____ Agency _____

Email _____ Phone _____

Client Demographic & Contact Information

Legal Name _____ Gender _____

Preferred Name _____ Pronouns_____

Date of Birth (MM/DD/YYYY) _____ Age _____

Social Security Number _____ Preferred Language _____

Primary Race _____ Ethnicity _____

Phone Number _____ Email _____

Alternate Phone Number _____ Address_____

Housing History

1. Is the client currently experiencing literal homelessness? ☐ Yes ☐ No
   (i.e. sleeping on the street, at a park, hotel/motel, or emergency shelter)

2. In the last 3 years, how many months has the client been literally homeless? _____

3. In the last 3 years, how many times has the client experienced homelessness? _____

4. Where has the client slept in the past **90 days**? (Select all that apply.)
   - ☐ Emergency Shelter
   - ☐ Safe Haven
   - ☐ Doubling up
   - ☐ Hospital (for less than 90 days)
   - ☐ Group Home/ Foster Care
   - ☐ Parent/ Guardian Home
   - ☐ Other (specify): _____
   - ☐ Transitional Housing
   - ☐ Couch surfing
   - ☐ Place not Meant for Human Habitation
   - ☐ Detention Center (for less than 90 days)
   - ☐ Hotel/Motel/Campground
   - ☐ Own Apartment

5. Is the client doubled-up or couch surfing? ☐ Yes ☐ No

   5A. If "Yes", how many months has the client been double-up or couch surfing? _____

6. Is the client at imminent risk (14 days or fewer) of becoming literally homeless? ☐ Yes ☐ No

7. Is client currently under lease or other housing contract? ☐ Yes ☐ No

   7A. If "Yes", what is the end date: _____

8. Has the client been evicted? (This only applies if the client was a leasee.) ☐ Yes ☐ No

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Housing Plan

1. Does the client have a housing need identified in their Plan of Care*? ☐ Yes ☐ No
   (*Please note: If a client is selected, this is required prior to move-in.)

   1A. If "No", what are the client's current goals and needs related to housing stability?

   _____

   _____

2. Please explain the client's housing plan. How will this apartment assist the client in moving forward, and what would be their short-term (first 30-90 days) and long-term (1 year) plan?

   _____

   _____

   _____

3. What actions has the client and/or client's team already taken toward stabilizing the client's housing?

   _____

   _____

   _____

Additional space is available at the end of the Screening Form if needed.

Brief Vulnerability Pre-Screen

1. Was the client living in a foster care placement until they aged out? ☐ Yes ☐ No
2. Did the client runaway or get kicked out any time before age 18? ☐ Yes ☐ No
3. Was the client incarcerated prior to age 18? ☐ Yes ☐ No
4. Has the client ever lost housing due to religious or ideological differences? ☐ Yes ☐ No
5. If the client has ever tried marijuana, was the first use at or before age 12? ☐ Yes ☐ No
6. Is the client fleeing or at risk of violence, trafficking, or exploitation? ☐ Yes ☐ No
7. Is the client pregnant or parenting? ☐ Yes ☐ No
8. Does the client identify as LGBTQ+? ☐ Yes ☐ No
9. Is client a veteran? ☐ Yes ☐ No
10. Has the client been diagnosed with one or more of the following? (Select all that apply.)
    - ☐ Substance use disorder
    - ☐ Serious mental illness
    - ☐ Developmental disability
    - ☐ Post-traumatic stress disorder
    - ☐ Cognitive impairments resulting from brain injury
    - ☐ Chronic physical illness or disability
    - ☐ HIV/AIDS
    - ☐ Other: _____

11. Is the client on the Sex Offender Registry? ☐ Yes ☐ No

12. Does the client have any felony convictions or open criminal cases? ☐ Yes ☐ No
12A. If "Yes", please list _____

Independent Living

1. Does the client work with a Life Skills Provider or IDSP? ☐ Yes ☐ No
(Please note: If a client is selected, this is required prior to move-in.)

2. Does client have independent living skills or adequate supports to safely live independently and complete daily tasks? ☐ Yes ☐ No

3. Does the client have the financial literacy skills necessary to live independently (i.e. budgeting, understands credit, pay bills, etc.)? ☐ Yes ☐ No

4. Does the client have adequate savings for a security deposit on their own apartment? ☐ Yes ☐ No

5. What is the clients **monthly** income (please include earned income, SSI/SSDI, child support, etc.)? $_____

6. Is client currently employed? ☐ Yes ☐ No

6A. If "Yes", how many **months** has client been at their current job? _____

6B. How many hours per week does the client work on average? _____

7. Is the client currently enrolled and attending an adult education, post-secondary, or job training program? ☐ Yes ☐ No

8. Is the client comfortable living alone, without a roommate/housemate? ☐ Yes ☐ No

9. Does the client know who to contact in case of personal crisis, medical emergency, or other after-hours concerns? ☐ Yes ☐ No

10. Does client have a Social Security Card AND State ID? ☐ Yes ☐ No

Certification

CC Signature _____ Date _____

Client Signature _____ Date _____

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Additional Space for Housing Plan (Narrative Questions 1A – 3)

_____

_____

_____

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Documentation Checklist

A completed referral packet for clients interested in placement in Clarke Square Wraparound Housing units will include all the following documents.

☐ Completed Wraparound Housing at Clarke Square Screening Form
☐ Copy of completed Provider Referral Form
☐ Copy of client's Plan of Care identifying their housing need
☐ Completed Wraparound Milwaukee Release & Exchange of Information for the following entities:

- Cardinal Capital Management, Inc.
- Clarke Square Building Manager, Roosevelt Veal
- Milwaukee County Housing Division
- Milwaukee Continuum of Care Providers

Completed documents can be emailed to the Community Intervention Specialist, April Rammer at april.rammer@milwaukeecountywi.gov with a subject line containing the client's initials followed by "Clarke Square Referral" (e.g. AR Clarke Square Referral).

Internal Use Only:

Date Received _____ Referral Complete ☐ Yes ☐ No:_____
Screening Status ☐ Eligible ☐ In-Eligible ☐ Incomplete
Prioritization Placement ☐ Cat.1-R ☐ Cat. 1-NS ☐ Cat. 2-R ☐ Cat. 2-NS ☐ Other:_____
Notes _____
Date CC Notified _____ Method ☐ Phone ☐ Email ☐ Other: _____
Date Client Contact _____ Method ☐ Phone ☐ Email ☐ Other: _____
Referrals _____