Housing Services 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) _____ Social Security Number _____

Primary Race _____ Ethnicity _____

Secondary Race _____ Preferred Language _____

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. 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 30 days? (Select all that apply.)
   - ☐ Emergency Shelter
   - ☐ Safe Haven
   - ☐ Doubling up
   - ☐ Hospital (for less than 90 days)
   - ☐ Other (specify): _____
   - ☐ Transitional Housing
   - ☐ Couch surfing
   - ☐ Place not Meant for Human Habitation
   - ☐ Detention Center (for less than 90 days)

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

6. Is client currently under lease or other housing contract? ☐ Yes ☐ No
   6A. If "Yes", what is the end date: _____

7. Is the client at imminent risk (14 days or fewer) of becoming literally homeless? ☐ Yes ☐ No
   7A. If "Yes", briefly explain the client's situation and their **housing plan**.

   _____

   _____

   _____

Client Brief Vulnerability Pre-Screen

1. Was the client living in a foster care placement until they aged out? ☐ Yes ☐ No
2. Is the client fleeing DV, trafficking, or a risk of trafficking? ☐ Yes ☐ No
3. Is the client currently pregnant? ☐ Yes ☐ No
4. Does the client identify as LGBTQ+? ☐ Yes ☐ No
5. Is client a veteran? ☐ Yes ☐ No
6. Does the client have severe and persistent disability that substantially impedes their ability to live independently? ☐ Yes ☐ No
7. 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: _____

Housing Preferences

1. Would the client prefer housing with on-site supportive services: ☐ Yes ☐ No

   1A. Does client have independent living skills or adequate supports to safely live independently and complete daily tasks? ☐ Yes ☐ No

   1B. Does client have financial literacy skills or relevant support? ☐ Yes ☐ No
2. Would the client prefer a roommate/housemate? ☐ Yes ☐ No
3. Would the client prefer to live in specific neighborhoods or areas of the city? ☐ Yes ☐ No
   3A. If "Yes", please list areas where the client **wants** to live:

   _____

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Client Household

1. Is the client a single unaccompanied individual? ☐ Yes ☐ No

1A. Does client have dependent children who live with them? ☐ Yes ☐ No

Name _____ Gender _____ Date of Birth _____

Name _____ Gender _____ Date of Birth _____

Name _____ Gender _____ Date of Birth _____

Name _____ Gender _____ Date of Birth _____

1B. Does client have a partner or adult family member who must live with them? ☐ Yes ☐ No

Adult 1 Name _____ Adult 2 Name _____

Date of Birth _____ Date of Birth _____

Relationship to Client _____ Relationship to Client _____

Monthly Income _____ Monthly Income _____

2. Is the client, or any member of the client's household (listed above), on the Sex Offender Registry? ☐ Yes ☐ No

3. Does the client, or any member of the client's household (listed above), have any felony convictions? ☐ Yes ☐ No

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

5. Is client currently employed? ☐ Yes ☐ No

   5A. If "Yes", how many **months** has client been at their current job? _____

6. Does client, and other members of client's household (listed above), have a SS Card AND State ID? ☐ Yes ☐ No

Certification

CC Signature _____ Date _____

Client Signature _____ Date _____

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Additional Space for Client or Household Information (Optional)

_____

_____

_____

_____

_____

Recommended Documentation Checklist

Please ensure a completed **Wraparound Milwaukee Release & Exchange of Information** for the following entities has been submitted to the CIS.

- ☐ Milwaukee County Housing Division
- ☐ Milwaukee Continuum of Care Providers
- ☐ Impact, Inc.

The following documents are required to verify eligibility for all HUD-funded housing programs. Having copies of these documents readily available may expedite the client's access to services. These documents are also required for other people in the client's household (children or adults listed on page 3).

- ☐ Social Security Card or valid document with SSN
- ☐ State ID
- ☐ Income Verification
- ☐ Disability Verification

For any questions or assistance completing this form, please contact April Rammer at 414-651-4317 or april.rammer@milwaukeecountywi.gov. Completed forms can be submitted by emailed to the same address.

Internal Use Only:

Date Received _____ Determination ☐ Enrolled ☐ In-Eligible ☐ Other: _____

Notes _____

Date CC Notified _____ Method ☐ Phone ☐ Email ☐ Other: _____

Date Client Contact _____ Method ☐ Phone ☐ Email ☐ Other: _____

Referrals _____