Annual HUD PSH Provider Assessment of Service Needs and Utilization (HEARTH Requirement)

Client Information:

Agency: _____ Program: _____
Last name: _____ First Name: _____
Bldg.: _____ Unit_____ Move-In Date (mm/dd/yyyy): __/__/____
Subsidy Type: _____

Annual Assessment Date (today's date): (mm/dd/yyyy): __/__/____

Staff Information:

Staff Name: _____
Staff e-mail: _____
Staff Phone Number: (___)___-____

Combined Client and Staff Response Section:

Start of Columbus Service Point Data Needed for Annual Assessment

1. Total Monthly Income: $_____

2. Income Received from Any Source? ☐ Yes ☐ No

	Receiving (Y/N)	Start Date	End Date	Amount
Alimony or other spousal support				
Child Support				
Earned Income				
General Assistance				
Other				
Pension from former job				
Private Disability Insurance				
Retirement income from Social Security				
SSDI				
SSI				
TANF				
Unemployment Insurance				
Veteran's Non-Service Connected Disability Pension				
Veteran's Service Connected Disability Compensation				
Worker's Compensation				

3. Non-Cash Benefits Received? ☐ Yes ☐ No

	Receiving (Y/N)	Start Date	End Date	Amount
Section 8, Public Housing, or Other				

Ongoing Rental Assistance				
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)				
Supplemental Nutrition Program (SNAP)				
TANF Childcare Services				
TANF Transportation Services				
Other TANF funded Services				
Temporary Rental Assistance				
Other Source				

4. Health Insurance Benefits Received? ☐ Yes ☐ No

	Receiving (Y/N)	Start Date	End Date
Employer-Provided Health Insurance			
Health Insurance Obtained through COBRA			
Medicaid			
Medicare			
Private Pay Health Insurance			
State Children's Health Insurance Program (SCHIP)			
State Health Insurance for Adults			
VA Medical Services			

5. Are you working currently Employed? ☐ Yes ☐ No

IF YES (provide information below designated by underlining or circling):

If employed, average number of hours worked/ week?					
If current employed, tenure?	Permanent	Temporary	Seasonal	Don't Know	Refused
If unemployed, looking for work?	Yes	No	Don't Know	Refused	

6. Disabling Conditions

Disability Type	Check if Yes	Disability Determination	Currently Receiving Services	Condition going to be long-term
Alcohol Abuse				
Alcohol and Drug Abuse				
Chronic Health Condition				
Developmental Disability				
Drug Abuse				

HIV/AIDS				
Mental/Emotional Health				
Physical Disability				

7. Domestic Violence Survivor within the last 12 months:
☐ Yes ☐ No ☐ Don't Know ☐ Refused

(If yes, Underline/Circle appropriate response)

Current Relationship	1 – 3 months ago	4 – 6 months ago	7 – 12 months ago	**Don't Know**	Refused

8. In School or Working on a Degree in the last 12 months:
☐ Yes ☐ No ☐ Don't Know ☐ Refused

9. Received Vocational Training in the last 12 months:

☐ Yes ☐ No ☐ Don't Know ☐ Refused

10. Highest Level of Education Attained in the last 12 months: (Underline/Circle appropriate education level)

No history of formal education	Nursery to 4th	5th or 6th	7th or 8th	9th or 10th	11th
12th, no diploma	GED	12th with high school diploma	Some college (post-secondary)	Associates Degree	**Bachelor's** Degree
Master's Degree	Other	Refused	No schooling completed in the last 12 months		

11. Specific Degree(s) Earned in the last 12 months:

_____

End of Columbus Service Point Data Needed for Annual Assessment

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CLIENT RESPONSE SECTION:

General Housing, Rent, and Utilities

1. Are you current in your rent?
   - ☐ Yes
   - ☐ No
   - ☐ N/A (client has 0 rent)

2. For how many months have you consistently paid your rent?

☐ 0	☐ 3	☐ 6	☐ 9	☐ 12
☐ 1	☐ 4	☐ 7	☐ 10	☐ N/A (client has 0 rent)
☐ 2	☐ 5	☐ 8	☐ 11	

3. Do you have utilities set-up in your name?
   - ☐ Yes
   - ☐ No
   - ☐ N/A to unit

4. Would you able to set-up utilities in your name?
   - ☐ Yes
   - ☐ Yes with Conditions (on payment plan)
   - ☐ No
   - ☐ Unknown

   If No, please explain barrier: _____
   _____

5. Have you thought about wanting to move to a more independent setting?
   - ☐ Yes
   - ☐ No

Employment/Education:

1. Are you aware that Benefits Planning Services are available to assist all people working and/or going to school while maintaining their benefits? ☐ Yes ☐ No

2. What type of job are you most interested in?
   _____
   _____

3. What other types of jobs would you also be willing to consider?

_____

_____

4. Which of the following would you be interested in exploring this next year:

- ☐ Benefits Planning Services
- ☐ Competitive Work/Supported Employment Program
- ☐ Transitional Employment/Work Adjustment Program
- ☐ GED Classes and Testing
- ☐ Vocational Assessment
- ☐ Community Based Assessment
- ☐ Literacy/Learning Disability Assessment
- ☐ Functional Capacity Assessment
- ☐ Job Development/Placement Services
- ☐ Job Coaching/Job Training
- ☐ Vocational School/Trade School
- ☐ Apprentice Program
- ☐ Job Readiness Activities and/or Group

Criminal Activity:

1. Have you been convicted of a crime in the past 12 months? ☐ Yes ☐ No

   a. Did the offense include the sale or use of illicit drugs? ☐ Yes ☐ No
   b. Was the offense a crime against another person, including domestic violence? ☐ Yes ☐ No
   c. Was the offense a felony conviction? ☐ Yes ☐ No

2. Has your behavior resulted in police runs to you unit? ☐ Yes ☐ No

   If yes, how many police runs have occurred in the past year? _____

STAFF ASSESSMENT SECTION BEGINS ON NEXT PAGE

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STAFF ASSESSMENT SECTION: TO BE COMPLETED BY STAFF ONLY

General Housing, Rent, and Utilities:

1. Has the client expressed an interest in moving from supportive housing to mainstream housing? ☐ Yes ☐ No
2. Does the client have a regular source of income, earned or through benefits, for the last 6 months? ☐ Yes ☐ No
3. Has the client or any member of the household been convicted of or pled guilty to drug-related criminal activity within the last year? ☐ Yes ☐ No
4. Is the client a tenant in good standing? ☐ Yes ☐ No

Housing Inspections:

1. How many Housing Inspections were scheduled in the last 12 months? _____
2. How many housing inspections were completed in the last 12 months? _____
3. How many housing inspections did the client's unit pass in the last 12 months? _____
4. Has the client been in violation of his/her lease in the last 12 months? ☐ Yes ☐ No

   If yes please state the lease violation(s):_____
   _____
   _____
   _____

Substance Abuse and Mental Health:

1. What is the client's current status of substance abuse?
   Check all that apply. (Note this question is about abuse, not use.)

   a. No history of substance abuse or full remission for 1 year or more ☐
   b. Substance abuse in remission for less than 1 year. ☐
   c. History of treatment/engaged in treatment within the last year. ☐
   d. Actively abusing substance(s) at this time, several relapses, engagement needed. ☐

2. Does the client's current substance abuse contribute to his/her housing instability? ☐ Yes ☐ No

   What is the current state of the client's mental health symptoms?
   a. No mental health issues or full remission for 1 year or more ☐
   b. Symptom impair some functioning in treatment ☐
   c. Symptoms impair most functioning, client in treatment ☐
   d. Symptoms impair most functioning, client not in treatment ☐

3. Does the client's current mental health symptoms contribute to his/her housing stability? ☐ Yes ☐ No

   If yes please state the safety concern(s):_____
   _____
   _____
   _____

Physical Health:

1. What is the status of client's general health?

   a. No health known health issues, or health issues do not impair functioning. ☐ Yes ☐ No

   b. Known health issues impair some functioning, client receiving medical care. ☐ Yes ☐ No

   c. Known health issues impair most functioning, client receiving Treatment ☐ Yes ☐ No

   d. Known health issues impair most functioning, client receiving treatment. ☐ Yes ☐ No

   e. Known health issues impair most functioning, a higher level of care needs to be considered for client. ☐ Yes ☐ No

   f. Client has known health concerns and is refusing treatment. ☐ Yes ☐ No

2. Do known physical health issues contribute to housing instability for client? ☐ Yes ☐ No

3. When was the client's last physical health exam (mm/yyyy)? __/__/____

4. When was client's last dental exam (mm/yyyy)? __/__/____

Safety Concerns:

1. Does the client exhibit any of the following safety concerns:

a.	Fire-Setting	(If yes, specify date: (mm/dd/yyyy): __/__/____	☐ Yes	☐ No
b.	Homicidal Ideation	(If yes, specify date: (mm/dd/yyyy): __/__/____	☐ Yes	☐ No
c.	Attempt at Homicide	(If yes, specify date: (mm/dd/yyyy): __/__/____	☐ Yes	☐ No
d.	Suicidal Ideation	(If yes, specify date: (mm/dd/yyyy): __/__/____	☐ Yes	☐ No
e.	Suicide Attempt	(If yes, specify date: (mm/dd/yyyy): __/__/____	☐ Yes	☐ No
f.	Assaultive Behavior	(If yes, specify date: (mm/dd/yyyy): __/__/____	☐ Yes	☐ No
g.	Has an Incident Report had to be generated on the client in last 12 months for safety concerns?		☐ Yes	☐ No

If yes please state the safety concern(s):_____
_____
_____
_____

PART II: TO BE COMPLETED BY STAFF ONLY

Living Skills:

The following questions will be used to gauge the client's ability to live in a more independent housing environment.

1 = Requires continual/consistent (weekly or more) outreach/assistance to participate in PSH supportive services plan and related treatment.

2 = Requires frequent (once a month) staff intervention to participate in PSH supportive services plan and related treatment.

3 = Requires occasional (once every 2 to 3 months) staff intervention to participate in PSH supportive services plan and related treatment.

4 = Initiates meeting with staff to express concerns/issues and develop a plan for resolution, but pursues resolutions independently with mostly successful results/

5 = Does not require staff assistance

1. How do you rate the client on the ability to provide daily upkeep of his/her apartment?
☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

2. How do you rate the client's ability to provide of ask for maintenance on his/her unit?
☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

3. How do you rate the client's ability to manage his or her finances?
☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

4. How do you rate the client's ability to shop for food?
☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

5. How do you rate the client's ability to prepare food?
☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

6. How do you rate the client's ability to care for his/her personal appearance and hygiene?
☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

7. How do you rate the client's ability to manage medication and health issues?
☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

8. How do you rate the client's ability to obtain and utilize transportation?
☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

9. How do you rate the client's ability to find and utilize community resources?
☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

PART III: TO BE COMPLETED BY STAFF ONLY

Community Support

1. Is the client currently receiving supportive services in the community as recommended in his/her Individualized Service Plan? ☐ Yes ☐ No

2. Does the client have family members, friends, and/or other social support systems established in the community? ☐ Yes ☐ No

3. Please check all supportive services the resident has received in the 12 months:

   a. Benefits Assistance: Assistance with eligibility criteria; consultation and advice; help in completing benefits application forms; negotiation on behalf of client; representation of client ☐

b. Material Goods: Clothing, personal hygiene items, food, and transportation ☐

c. Temporary Financial Assistance: Rent payment and deposit. ☐

d. Housing Search and Information: Housing Search ☐

e. Consumer Assistance and Protection: Money management counseling, payeeship; acquiring identification/social security card ☐

f. Criminal Justice and Legal Services: Legal counseling and immigration Services ☐

g. Case/Care Management: Development of plans for the evaluation, treatment, and/or care of persons needing assistance in planning and arranging for the acquisition of community services ☐

h. Day Care: Child care centers and infant care centers ☐

i. Personal Enrichment/Wellness: Life skills education, social skills training, and stress management ☐

j. Outreach Programs: Homeless Street Outreach services: housing, AOD, mental health and/or physical healthcare ☐

STAFF RECOMMENDATION FOR CLIENT TO MOVE FROM SUPPORTIVE HOUSING TO MORE INDEPENDENT HOUSING WITHIN THE NEXT 12 MONTHS:

1. ☐ Recommend
2. ☐ Recommend with conditions
3. ☐ Do NOT recommend

Please provide the following information to support the box checked above:

A. What the resident will be asked to do in order to move to more independent/ mainstream housing in the next 12 months OR to improve in order to move on to more independent/mainstream housing in the future (to be incorporated in individualized goal plan).
   1.
   2.
   3.

4.
5.

B. What the supportive service staff will do to assist client in preparing to move in the next 12 months or to assist client in increasing his/her readiness to move to more independent/mainstream housing in the future (to be incorporated in individualized goal plan).
   1.
   2.
   3.
   4.
   5.

C. **Additional Comments: Other comments relevant to meeting the client's individual** service needs and ability **to sustain more independent housing to client's support system, client's ability to keep appointments, availability of housing subsidy, and** other relevant information:

Signatures

Staff Member Signature: _____ Date: __/__/____

Supervisor Signature: _____ Date: __/__/____