Amerigroup
An Anthem Company

https://providers.amerigroup.com

Foundational Community Supports: Supportive Housing Assessment

☐ Initial assessment ☐ Reauthorization

**Indicates a required field.*

***Date:**	***Name:**	***ProviderOne ID:**	***DOB:**
Address (not required if homeless):		***City, State ZIP:**	
Phone number:		**Email:**	
Member of a federally recognized American Indian/Alaska Native tribe? ☐ Yes ☐ No *If Yes, specify which tribe:*		**Veteran:** ☐ Yes ☐ No ***Provider agency name:**	

Part A: Complex needs eligibility requirements
Information in this section is required in order to determine eligibility for supportive housing services.

*** Health need (must select at least one)**
The client meets one of the following criteria (as determined by a licensed behavioral health agency):

☐ Mental health need where there is a need for improvement, stabilization or prevention of deterioration to functioning resulting from the presence of a mental illness

☐ Diagnosed with a substance use disorder, as determined by meeting a one or higher level on the *American Society of Addiction Medicine Criteria*

☐ Needs assistance with three or more activities of daily living (ADL) or one or more hands-on ADL (as determined by a Comprehensive Assessment and Reporting Evaluation)

☐ The client is a homeless individual with a disability, determined by a coordinated entry assessment. *(Individual assessed to have a complex health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization or prevention of deterioration of functioning [including ability to live independently without support]).*

*** Risk factors (to be approved by a qualified professional; must select at least one risk factor):**

☐ **Chronically homeless:** an individual with a disabling condition who has been homeless for a period of at least one year, **or** an individual with a disabling condition who has had at least four episodes of homelessness, as long as the combined occasions equal at least 12 months.

Note: *This definition also includes individuals who previously met the U.S. Department of Housing and Urban Development (HUD) definition of chronic homelessness but have been housed in the last 60 days (Time housed may not exceed 60 days).*

☐ **Frequent or lengthy institutional contacts (frequent, as in two or more instances in the past 12 months, or lengthy, as in lasting 90 days or more)**

Is the client transitioning out of an institutional setting? ☐ Yes ☐ No

If yes, select all that apply:

- ☐ Nursing
- ☐ Inpatient psychiatric hospital
- ☐ Inpatient medical hospital
- ☐ Correctional program or institution
- ☐ Foster care facility or other youth facility

Note: *Services will not be authorized if the client is currently placed in an institution for mental disease (IMD) or correctional facility until they transition out of the setting.*

Has the client resided within one of the previously listed institutional settings multiple times in the past year? ☐ Yes ☐ No *If yes, number of times:*_____

☐ **Frequent residential care stays (two or more occurrences in the past 12 months)**

Has the client resided within a residential care facility two or more times in the past 12 months? ☐Yes ☐ No

If yes, select all that apply:

- ☐ Evaluation and treatment facility
- ☐ Inpatient substance use treatment facility
- ☐ Detox center
- ☐ Adult residential care, assisted living or adult family home (AFH)

☐ **Frequent turnover of in-home caregivers (three or more occurrences in the past 12 months)**

Within the last 12 months, has the client used three (or more) different in-home caregiver providers (Please provide supporting documentation with the assessment)? ☐ Yes ☐ No

☐ ***PRISM*** **score (1.5 or above)** *(Contact the TPA, MCO, BHO, Health Home or HCS case manager to obtain the PRISM risk score.)*

Additional details on risk factors:

Part B: Housing assessment
Please fill out to the best of your ability. This information is required but does not impact eligibility.

*** Employment status:**

☐ Unemployed
☐ Employed part time
☐ Employed full time
☐ Nonpaid employment activities
☐ Enrolled in training/education program

***Income source:**

☐ Social Security
☐ Pension
☐ Social Security Income
☐ Social Security Disability Income
☐ Temporary Aid for Needy Families
☐ Housing and Essential Needs
☐ Aged, blind or disabled
☐ Employment
☐ Other: _____

***Total income:**

☐ Less than $10,000
☐ $10,000 to $14,999
☐ $15,000 to $19,999
☐ $20,000 to $24,999
☐ $25,000 to $29,999
☐ $30,000 to $34,999
☐ $35,000 or more

***Housing type:**

☐ Transitional/temporary housing
☐ Permanent housing
☐ Not housed (homeless)

***If homeless, choose type**:

☐ Living in a place not meant for human habitation (for example, car)
☐ In an emergency shelter
☐ Homeless but admitted to a hospital or other institution for less than 30 days
☐ At imminent risk of losing housing
☐ Evicted or foreclosed within 30 days with no future residence identified
☐ Couch surfing or doubled up
☐ Other: _____

Strengths

Please fill out to the best of your ability. Information in this section assesses the individual's housing preferences, needs and assets. This information does not impact eligibility.

Identify individual traits that support the client's ability to obtain and maintain housing. Select all that apply:

☐ Arranging apartment repairs
☐ Desire to work or engage in community activities
☐ Driving/using public transportation
☐ Filling prescriptions
☐ Getting along with neighbors, landlords, etc.
☐ Housekeeping
☐ Hygiene
☐ Lease compliance
☐ Long-term rental history
☐ Maintaining benefits
☐ Managing health care needs
☐ Managing/using caregivers
☐ Meal preparation
☐ Money management
☐ Motivated to obtain housing
☐ Motivated to resolve legal/credit issues
☐ Paying bills
☐ Paying rent/utilities
☐ Shopping for food and necessities
☐ Support from family/friends
☐ Support from family/friends
☐ Taking medication
☐ Other: _____

Housing preference Setting:

☐ Urban/downtown ☐ Urban/residential neighborhood ☐ Suburban ☐ Rural/small town

Close to:

☐ Transportation ☐ Shopping ☐ Medical services ☐ Family/friends ☐ Place of worship
☐ Recreation/cultural ☐ Other: _____

Living space:

☐ Studio ☐ 1 bedroom ☐ 2 bedroom ☐ Onsite laundry ☐ Nonsmoking
☐ Smoking allowed ☐ Pets allowed ☐ Bottom floor/elevator ☐ Accessible unit ☐ Parking

Please describe other relevant housing preferences:

Personal information related to housing placement Does the client use a wheelchair? ☐ Yes ☐ No

If yes, please list:

Width: _____ Manual or electric: _____

Does the client have a pet? ☐ Yes ☐ No

Does the client have a service animal? ☐ Yes ☐ No

Does the client smoke? ☐ Yes ☐ No

Does the client use medical marijuana? ☐ Yes ☐ No

Has the client served in the U.S. military with a qualified discharge? ☐ Yes ☐ No

Has the client ever been arrested? ☐ Yes ☐ No

If yes, was the client charged and convicted of a crime? ☐ Yes ☐ No

Is the client a registered sex offender or been convicted of manufacturing methamphetamines? ☐ Yes ☐ No
(*If yes, no federal subsidies allowable*)

Will anyone else be living with the client? ☐ Yes ☐ No

If yes, select type, and list name and contact information: ☐ Family/partner/friend:
☐ Live-in aide:

Please describe other relevant personal information related to housing placement:

Housing history

Does the client have any rental history? ☐ Yes ☐ No
Has the client ever received subsidized housing from a public housing authority? ☐ Yes ☐ No
Does the client owe anyone or any public housing authority past-due rent? ☐ Yes ☐ No
Has the client ever been evicted from rental housing? ☐ Yes ☐ No
If yes, please list dates:

Transportation information

Does the client rely on public transportation? ☐ Yes ☐ No
Does the client have a vehicle? ☐ Yes ☐ No
Describe the client's transportation needs:

Housing options to review/explore

Are any of the options below available and appropriate for the individual? ☐ Yes ☐ No
If yes, select all that apply:

Tenant-based rental assistance:

☐ Housing choice
☐ Nonelderly disabled
☐ Veteran's Assistance Supportive Housing
☐ Family Unification Program
☐ HOPWA
☐ Other: _____

Project-based rental subsidy:

☐ HUD 811
☐ HUD 202
☐ Low-Income Housing Tax Credit
☐ Other: _____

Continuum of care:

☐ Shelter care
☐ HPRP
☐ Permanent supportive housing
☐ Transitional housing
☐ Other: _____

Department of Commerce subsidized:

Other HUD or USDA subsidy:

County/city program:

Other:

Documentation available:

☐ Social Security card
☐ Background check results
☐ Proof of income
☐ Documentation of other assets
☐ Birth certificate
☐ Legal resident status
☐ Protective payee

Notes:

Assessment completed by:	**Position/credentials:**	**Date:**
Signature:	* **Provider name:**	
Assessment supervised by (if applicable):	**Position/credentials:**	**Date:**
Signature:		
* **Enrollee consent for services (print name):** *Please indicate verbal consent in the notes below if signature was not attainable (required if no signature)*		
* **Enrollee signature:**		* **Date:**
Notes:		