**SMAC Rapid Resolution Guide**

**Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HMIS ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Screener Instructions**:

This is designed to help guide your conversation, and space is provided to take notes. Use the following best practices:

* Introduce yourself, your agency and your role
* Assure confidentiality
* Client choice –
	+ Responses are not necessary
	+ The more information provided, the more creative the options can be
* Encourage questions/concerns/complaints along the way – answer/address/direct to appropriate staff as needed
* Remind the household that completion of any screening does not guarantee housing
* This process is the beginning step to look at what type of resources within the suburban metro counties (Anoka, Scott, Carver, Dakota, and Washington) might help them find and stay in housing
* Before beginning:
	+ Do you have any questions before we begin?

**COVID-19 Survey - MN**

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| --- |
| **Date of Survey:** |
| In the last two weeks, have you been in close contact with anyone who is experiencing fever, new or worsening cough, and shortness of breath (symptomatic or likely have COVID-19)?  | ☐ Yes ☐ No |
| Have you been asked or chosen to keep yourself away from others (quarantine) because you’ve been in contact with others who likely have COVID-19? ☐ Yes ☐ No | If yes, have you kept yourself away from others (quarantined) since that time?☐ Yes ☐ No |
| Staff use: Was the client screened for COVID-19 symptoms? | ☐ Yes ☐ No |
| Are you currently experiencing any symptoms consistent with COVID-19 (fever, new or worsening cough, shortness of breath)? ☐ Yes ☐ No | If yes, date symptoms began: If yes, were you tested for COVID-19? ☐ Yes ☐ No  |
| If yes, outcome of COVID-19 test results once received? ☐ Confirmed COVID-19 ☐ Negative | Date symptoms ended: |
| Have you been asked or chosen to stay away from others (isolate) because you have or likely have COVID-19?☐ Yes ☐ No | If yes, have you kept yourself away from others (isolate) since that time? ☐ Yes ☐ NoDate isolation ended: |

**Active Listening: Allow the person to tell the story of their housing crisis.**

(In-person, phone, etc.)

|  |  |  |
| --- | --- | --- |
| **Date of Assessment** | **Assessment Location** | **Assessment Type** |
|  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Assessor’s Name** | **Assessor’s Organization** | **Assessor’s Phone** | **Assessor’s Email** |
|  |  |  |  |

**Client Information**

|  |
| --- |
| Social Security Number: |
| Client Date of Birth: |
| **Gender Identity:**☐ Female ☐ Male ☐ A gender other than singularly male or female (e.g. nonbinary, gender fluid, agender, culturally specific gender) ☐ Transgender ☐ Questioning☐ Client Doesn’t Know ☐ Client RefusedGender Pronouns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Race:**  | ☐American Indian, Alaska Native, or indigenous ☐Asian or Asian American ☐Black, African American, or African ☐Native Hawaiian or Pacific Islander ☐White ☐Client doesn’t know ☐Client Refused |
| **Ethnicity:** | ☐Hispanic/Latino(a/o/x) ☐Non-Hispanic/Non-Latino(a/o/x) ☐Client doesn’t know ☐Client Refused |
| **Are you Native American?** | ☐Yes ☐No  | If yes, of which tribe are you an enrolled member? |  |
| **U.S. Military Veteran?** | ☐Yes ☐No [ ] Client Doesn’t Know [ ] Client Refused |

|  |  |
| --- | --- |
| Does client have a disability of long duration? | ☐Yes ☐ No |
| Do you have a serious mental illness? | ☐Yes ☐ No |
| Medical Assistance (MA) Status: | ☐Active ☐Likely Eligible ☐ Likely Not Eligible |

Client Location (CoC):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County where client resides: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Contact Information:**

|  |  |
| --- | --- |
| Phone number where you can be reached or a message can be left: |  |
| Email where you can be reached or where a message can be sent: |  |

**Household Information**

|  |  |
| --- | --- |
| Household Type | ☐ Single ☐ Family☐ Youth – Single ☐ Youth – Family  |
| Household Size: Total # of Persons |  |
| Household Size: Total # of Children (17 and under): |  |
| Household Size: Total # of Adults (18+) |  |

**Where do you tend to stay at night?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- |
| Extent of Homelessness by MN’s definition:  | ☐ 1st time homeless and less than 1 year without a home☐ Multiple times homeless, but NOT meeting LTH definition ☐ Long Term Homeless  |

**Current Living Situation**

|  |  |
| --- | --- |
| Information Date | Current Living Situation (Shelter, PNMFHH, Staying with family, friends, etc.) |
|  |  |

|  |  |
| --- | --- |
| Is anyone CURRENTLY trying to harm you, control your daily activities, resources, and/or documents, or force you to do things you don’t want to do? | ☐Yes ☐ No |

Script: Thank you for sharing with me. There are advocacy resources available for both people who are currently experiencing violence as well as those who experienced it in the past. You deserve to be safe and have support around you. I can provide you with contact information for an advocate or we can call them right now. (Day 1 number is 866-223-1111)

|  |  |
| --- | --- |
| **If the person is living in a Place Not Meant for Human Habitation, ask the following question:** If there was an emergency shelter bed available, would you take it?  | ☐Yes ☐ No |

## Housing Crisis Resolution Plan

Things for the person to consider: What does the plan look like? Have you tried something like it before? Are there any safety concerns? What is the timeline? What resources do you need? If this doesn’t work, what is the backup plan?

**Housing Stabilization Services Questions**

The following series is required to help determine eligibility for DHS Housing Stabilization Services.

Based on your experience with the person you have assessed for Coordinated Entry, review the following 5 questions and use your professional judgement when selecting your responses.

1. Housing Instability: Is this person experiencing housing instability? [ ] Yes [ ] No
2. Communication: Does this person need support communicating their needs to help with housing? [ ] Yes [ ] No
3. Mobility: Does this person need support getting around to help with housing? [ ] Yes [ ] No
4. Decision Making: Does this person need support in decision making related to their housing? [ ] Yes [ ] No
5. Managing Challenging Behaviors: Does this person need support managing challenging behaviors to help with housing? [ ] Yes [ ] No

If yes to the question regarding housing instability, and yes to any of the remaining questions, the individual meets the Assessed Need and Housing Instability observations for DHS Housing Stabilization Services.

**Exit Date:**

**Exit Destination:**

**Referrals/Services Provided:**

|  |  |
| --- | --- |
| [ ] Basic needs (i.e., food, material goods) | [ ]  Mental Health Counseling |
| [ ] Childcare assistance or subsidy | [ ]  MFIP Assistance |
| [ ] Criminal justice and legal assistance | [ ]  Money Management Counseling |
| [ ] Education | [ ]  Physical health |
| [ ] Employment | [ ]  Prevention resources |
| [ ]  Food stamps or Benefits Card (SNAP) | [ ]  Substance abuse counseling |
| [ ]  Housing Stabilization Eligibility Documentation | [ ]  Veteran Registry |
| [ ]  Medicaid (MA) | [ ]  Other:  |

MA Eligibility: https://mn.db101.org/mn/programs/health\_coverage/medicaid-magi/program2.htm

Income-based MA:

1. If your family’s income is at or under **138% of the** **Federal Poverty Guidelines** (FPG) ($17,609 for an individual; $36,156 for a family of four), you may qualify for income-based Medical Assistance (MA).
2. Any **children under 19 or pregnant women** in your family may be able to get income-based Medical Assistance (MA) coverage as long as your family’s income is at or under **280% of FPG** ($73,360 per year for a family of four). Note: For the purposes of calculating a pregnant woman’s family income, the unborn baby is counted as a family member.

Disability-based MA (for folks meeting Social Security definition of disability):

1. Disability-based MA doesn’t count all of your earned income, so you may make more and still qualify. Furthermore, people with disabilities who work and have higher income may qualify through MA-EPD.
2. You need certain services for people with disabilities, such as some Home and Community-Based Services (HCBS).
3. You also get Medicare. Usually, income-based Medical Assistance (MA) isn’t available to people getting Medicare, but disability-based Medical Assistance (MA) is. It may even help pay your monthly Medicare premiums.