

ANNUAL PSH RESIDENT SERVICE NEEDS & MOVE UP ASSESSMENT

The Annual Permanent Supportive Housing (PSH) Resident Service Needs & Move Up Assessment, effective 01/01/2020, replaces the former HEARTH Assessment used for current PSH residents. PSH providers should assess ALL residents annually using this assessment.

Why are we doing the Annual PSH Resident Service Needs & Move UP Assessment?

The Annual PSH Resident Service Needs & Move Up Assessment is used to identify residents current service needs and whether they may be a good candidate for moving up from PSH. The assessment is used to identify possible gaps in needed services, housing-related barriers, and level of case management needed.

What is Move-Up?

Move-up is a strategy to assist residents of PSH who no longer need PSH services to move on to housing outside of the USHS. Move-up allows PSH units to be made available for other currently homeless individuals and families with long-periods of homelessness and severe service needs. This assessment is intended to help determine if a PSH resident is ready to move up. Potential candidates for move-up include:

- Residents who have been in PSH for a period of time and no longer need the supportive services.
- Residents who have demonstrated the ability to live stably and maintain housing.
- Residents who are ready, willing and able to move up to fair market rent or rent subsidized by another program.

Why are we asking these specific questions?

Factors that cause an individual or family to be stable in housing, or unstable and face a return to homelessness are varied and range from structural issues, such as lack of affordable housing and racism, to specific individual vulnerabilities (e.g., severe and persistent disabling condition(s)) and housing barriers (e.g., criminal record, prior evictions, or having little to no income). This assessment is intended to be brief and least invasive, so the questions in this tool do not account for all the possible factors associated with housing stability, but rather factors that most directly affect an individual or family's ability maintain housing with or without assistance. These items were narrowed down by representatives from PSH providers to best meet the needs of our community.

ANNUAL PSH RESIDENT SERVICE NEEDS & MOVE UP ASSESSMENT

DATE COMPLETED: _____

CLIENT NAME: _____

Part 1: RESIDENT INTERVIEW

Today we will discuss your current service needs. This assessment will be used to determine whether your service needs have changed, if you need to be referred to services in the community, or would be better served by another programming or housing option.

***This assessment should not be given to the resident to fill out, but rather be used for interviewing purposes.**

Question	Client Response	Case Manager Notes	Intervention Needed?
Are you currently receiving supportive services in the community that I may not be aware of?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have family members, friends, and/or other social support systems established in the community?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
When was your last physical health exam (mm/yyyy)?	____/____/____		
When was your last dental exam (mm/yyyy)?	____/____/____		
If you have a mental health provider, when is the last time you saw that person?	____/____/____ <input type="checkbox"/> N/A		

Question	Client Response	Case Manager Notes	Intervention Needed?
Do you need help contacting or reconnecting to your physical, dental, or mental healthcare provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Did you have any of the following safety concerns over the past year?	<input type="checkbox"/> Fire-Setting <input type="checkbox"/> Homicidal Ideation <input type="checkbox"/> Attempt at Homicide <input type="checkbox"/> Suicidal Ideation <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Assaultive Behavior <input type="checkbox"/> Hx of Overdose <input type="checkbox"/> Frequent Police Runs/911 Calls (Health Related) <input type="checkbox"/> Frequent Police Runs/911 Calls (Safety Related) <input type="checkbox"/> IV Drug Usage		
Are there any services that you need that you aren't currently receiving?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Is there anything you are interested in doing in the next year?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you interested in receiving more information in any of the following areas this year?	<input type="checkbox"/> Benefits Planning Services <input type="checkbox"/> Competitive Work/Supported Employment Program <input type="checkbox"/> Transitional Employment/Work Adjustment Program <input type="checkbox"/> GED Classes and Testing <input type="checkbox"/> Vocational Assessment <input type="checkbox"/> Community Based Assessment <input type="checkbox"/> Job Readiness Activities and/or Groups	<input type="checkbox"/> Literacy/Learning Disability Assessment <input type="checkbox"/> Functional Capacity Assessment <input type="checkbox"/> Job Development/Placement Services <input type="checkbox"/> Job Coaching/Job Training <input type="checkbox"/> Vocational School/Trade School <input type="checkbox"/> Apprentice Program	

Question	Client Response	Case Manager Notes
Have you thought about moving to a more independent setting?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you current in your rent?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (client has 0 rent)	
Are there other lease compliance issues or concerns?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
For how many months have you consistently paid your rent?	_____ <input type="checkbox"/> N/A (client has 0 rent)	
Do you have utilities set-up in your name?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A to unit	
Do you have any current physical health issues that contribute to housing instability?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have any current mental health symptoms that contribute to housing instability?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a regular source of income, earned or through benefits, for the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you currently have any open criminal cases or active warrants?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you or any member of the household been convicted of or pled guilty to a crime in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Question	Client Response	Case Manager Notes
If so, was the conviction one of the following?	<input type="checkbox"/> Drug-related <input type="checkbox"/> Crime against another person including domestic violence <input type="checkbox"/> A felony <input type="checkbox"/> N/A	
Do you have any of the following barriers to housing?	<input type="checkbox"/> Hx of Arson <input type="checkbox"/> Hx of Sexual Offense(s) <input type="checkbox"/> Large amount of money due to landlord(s) <input type="checkbox"/> Utility Arrears <input type="checkbox"/> Cannot receive a Section 8 voucher <input type="checkbox"/> Hx of Evictions	
Has any behavior resulted in police runs to your unit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, how many police runs have occurred in the past year?		
Do you need any Criminal Justice and Legal Services: Legal counseling and immigration Services?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you interested in working on a plan to move up to independent housing in the community now or in the next 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Rate the following questions on a scale from 1 to 5. (1 = no concerns/need less help than receiving, 3 = some concerns/amount of help is sufficient, 5 = significant concerns/need more help than receiving.)				
Question	Last Year <small>(Please fill in prior to assessment based on last year's assessment. If first annual, mark "N/A")</small>	This Year	Why this rating?	Case Manager Notes
How has this past year been for you?				
How do you rate your ability to provide daily upkeep of your apartment?				
How do you rate your ability to ask for maintenance on your unit?				
How do you rate your ability to manage your finances?				
How do you rate your ability to shop for and prepare food?				
How do you rate your ability to care for your personal appearance and hygiene?				
How do you rate your ability to obtain and utilize transportation?				
How do you rate your ability to find and utilize community resources?				

Part 2: STAFF ASSESSMENT & RECOMMENDATIONS

Please check the appropriate box.

Need Dimension Based on Recent Client History	Service Need Level				
	1	2	3	4	5
Physical Health	No known health issues, or health issues do not impair functioning <input type="checkbox"/>	Known health issues impair some functioning, client receiving medical care. <input type="checkbox"/>	Known health issues impair most functioning, client receiving Treatment <input type="checkbox"/>	Known health issues impair most functioning, a higher level of care needs to be considered for client. <input type="checkbox"/>	Client has known health concerns and is refusing treatment. <input type="checkbox"/>
Living Skills, including Budgeting	Does not require staff assistance <input type="checkbox"/>	Initiates meeting with staff to express concerns/issues and develop a plan for resolution, but pursues resolutions independently with mostly successful results/ <input type="checkbox"/>	Requires occasional (once every 2 to 3 months) staff intervention to participate in PSH supportive services plan and related treatment. <input type="checkbox"/>	Requires frequent (once a month) staff intervention to participate in PSH supportive services plan and related treatment. <input type="checkbox"/>	Requires continual/consistent (weekly or more) outreach/assistance to participate in PSH supportive services plan and related treatment. <input type="checkbox"/>
Basic Needs: food, clothing, hygiene	Needs met for 1 year <input type="checkbox"/>	Needs met for less than 1 year <input type="checkbox"/>	Requires help to meet needs <input type="checkbox"/>	Minimally met <input type="checkbox"/>	Unmet <input type="checkbox"/>
Benefits and Income Stream	Has income and has maintained it for 1 year <input type="checkbox"/>	Has income and has maintained it for less than 1 year <input type="checkbox"/>	Requires help to maintain <input type="checkbox"/>	Applied for but not received <input type="checkbox"/>	None; not applied for <input type="checkbox"/>
Mental Health Challenges	None apparent for 1 year <input type="checkbox"/>	None apparent for less than 1 year <input type="checkbox"/>	Occasional minor impairment <input type="checkbox"/>	Frequent minor impairment <input type="checkbox"/>	Frequent major impairment <input type="checkbox"/>

CSP# _____

Substance Abuse	None apparent for 1 year <input type="checkbox"/>	None apparent for less than 1 year <input type="checkbox"/>	Occasional minor abuse <input type="checkbox"/>	Frequent minor abuse <input type="checkbox"/>	Frequent major abuse <input type="checkbox"/>
Crisis Incidents	Limited or appropriately handled for 1 year <input type="checkbox"/>	Limited or appropriately handled for less than 1 year <input type="checkbox"/>	Intermittent crises, usually not appropriately handled <input type="checkbox"/>	Frequent crises, usually not appropriately handled <input type="checkbox"/>	Continual crises <input type="checkbox"/>
Inspections	Passes every inspection <input type="checkbox"/>	Passes most inspections <input type="checkbox"/>	Passes some inspections <input type="checkbox"/>	Fails most inspections <input type="checkbox"/>	Fails every inspection <input type="checkbox"/>
Engagement in Services	Doesn't need services <input type="checkbox"/>	Needs and uses Services <input type="checkbox"/>	Needs and occasionally uses <input type="checkbox"/>	Needs and rarely uses <input type="checkbox"/>	Needs, but refuses <input type="checkbox"/>
Level of Case Management Need Based on Highest Level of Need Indicated Above					
<input type="checkbox"/>	Very Low Intensity (highest rating=1)	Self-Management, Monthly Face to Face Meetings,			
<input type="checkbox"/>	Low Intensity (highest rating=2)	Monthly Face to Face Meetings			
<input type="checkbox"/>	Medium Intensity (highest rating=3)	Weekly Face to Face Meetings			
<input type="checkbox"/>	High Intensity (highest rating=4)	Daily or Multiple Weekly Face to Face Meetings			
<input type="checkbox"/>	Very High Intensity (highest rating=5)	Daily or Multiple Weekly Face to Face Meetings and/or May Have Higher Level of Need than PSH			
<p>If the score doesn't reflect an increase in intensity, but an increase is needed please justify below:</p> <hr/> <hr/> <hr/>					

CSP# _____

<p>Please use the Service Needs Assessment information above to determine if the client requires a change in level of case management and/or other more suitable housing</p>	<p><input type="checkbox"/> No change</p> <p><input type="checkbox"/> Higher Intensity Case Management Needed (Can be provided by current project)</p> <p><input type="checkbox"/> Lower Intensity Case Management Needed (Can be provided by current project)</p>	<p><input type="checkbox"/> Higher Intensity Case Management Needed (May be better served at a different project)</p> <p><input type="checkbox"/> Lower Intensity Case Management Needed (May be better served at different project)</p>	<p><input type="checkbox"/> Severe Intensity Case Management Needed (May be better served in an Institutional Setting)</p> <p><input type="checkbox"/> Very Low Intensity Case Management Needed (May be ready for Move-Up to non-PSH option)</p>
<p>Recommendation</p>	<p><i>Continue in project and adjust IHSP as needed</i></p>	<p><i>Consider transfer to more suitable PSH option and adjust IHSP as needed</i></p>	<p><i>Consider other community options, plan for more appropriate placement, and adjust IHSP as needed.</i></p>

Is the client a tenant in good standing? Yes No

Has an Incident Report had to be generated on the client in last 12 months for safety concerns?
 Yes No

Are there any significant safety concerns? Yes No

Is move-up recommended?
 Do NOT recommend
 Recommend (In IHSP, be sure to state what the client will do in the near term and long-term to work towards fair market housing or other move-up housing option(s) and whether they need staff assistance to be successful)

Staff Member Signature: _____

Date: ____/____/____

Supervisor Signature: _____

Date: ____/____/____