COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

COUNTYWIDE HOUSING, EMPLOYMENT & EDUCATION RESOURCE DEVELOPMENT
HOUSING ASSESSMENT FORM

Independent Living Skills

4. How would you rate the client's ability to communicate and interact with others in the public?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

5. Indicate which activities and/or services that client **cannot** effectively execute access and/or utilize?

- ☐ Bathing
- ☐ Care of Personal Hygiene
- ☐ Cooking/Preparing Foods
- ☐ Laundry
- ☐ Housekeeping/Cleaning
- ☐ Personal Safety/Fire/Home
- ☐ Access to Healthcare and Medical issues
- ☐ Access Grocery Stores
- ☐ Public/Private Transportation
- ☐ Use of public facilities(i.e post office)
- ☐ Budgeting/Banking/Money Management
- ☐ Social Skills/Interpersonal Relationships
- ☐ Control Emotions and Impulses
- ☐ Comfortable Access Crowded Places for Services
- ☐ Make Sensible Judgments And Decisions
- ☐ Paying Rent
- ☐ Maintain Pertinent Personal Documents and Files
- ☐ Live Independently w/ No Assistance
- ☐ Walk a Reasonable Distance
- ☐ Wait patiently in line for services

6. The reason that client cannot effectively execute this/these activities (ies) are due to Medical or Psychiatric Disability? Yes ☐ No ☐ If yes, please specify

_____

Psychiatric Information

7. What is the client's Psychiatric Diagnosis?

Axis I (please specify)	and/or	Axis II (please specify)
_____		_____
_____		_____
_____		_____
_____		_____

8. List the Names and Dosages of All Psychotropic Medications the Client is Currently Taking

Name	Dosage	Name	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Medical Information

9. Does client report having any of the following communicable infections?

☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Tuberculosis

☐ HIV/AIDS ☐ Other (specify) ☐ Hepatitis C ☐ Tuberculosis

10. Does client report having any of the following medical conditions, which affect their daily life?

☐ High Blood Pressure ☐ Diabetes ☐ Head Injury ☐ Legally Blind

☐ Legally Deaf ☐ Not Ambulatory ☐ Other (Specify)

Substance Use History

11. Indicate substance(s) the client reports to be currently using or has used in the past.

☐ Cocaine ☐ Marijuana ☐ Opiates ☐ Methamphetamines

☐ Alcohol ☐ LSD ☐ Mushrooms ☐ Ecstasy

☐ Others (please specify) _____

12. Date client reports last use: (month/year):_____ 13. Current Sobriety Time:_____

13. List All Issues, Events Persons and Locations/Geographic Area that Client Reports that his/her Substance Use is Encouraged by:_____

_____

_____

14. List the Name(s) and Contact Information of Recovery Programs that Client is Currently Enrolled/Involved In (include locations of AA/NA Meetings that the client constantly attends):

_____ _____

_____ _____

_____ _____

_____ _____

Statement of Client's Agreement

I,_____, (print client name) agree that all statements reported are factual information that can and will be used by the Department of Mental health (DMH) to assist me in locating emergency/transitional/permanent housing. I understand that DMH is responsible for assisting me in locating housing and is not committed to any financial responsibility associated with maintaining my housing unless otherwise specified and arranged by DMH

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Last Name..... First Name..... MIS# ..... Sex.....

Date of Assessment:..... Social Security# ..... Date of Birth.....

Age..... Ethnicity Background:..... Psychiatric Dx.....

Source(s) of Income..... Monthly Income..... .....

Current Address.....

.....

Home Phone# ..... Cell # .....Work#.....

Estimated Relocation Time (days/weeks/months):.....

Case Manager/Navigator's Name:.....Clinic: .....Service Area.....

Current & Preferred Living Conditions

1. Current Residence

- ☐ Homeless – No shelter
- ☐ Winter/All-year-round Shelter
- ☐ Specialized shelter Beds
- ☐ Temporarily housing in a motel
- ☐ Board and Care
- ☐ Residential Treatment
- ☐ Transitional Housing
- ☐ Sober Living/Shared Housing
- ☐ Drug Tx Program
- ☐ Housing alone or with others
- ☐ Project Based Section 8 Housing
- ☐ Tenant based Section 8 Housing

2. Preferred Housing type

- ☐ Homeless – No shelter
- ☐ Winter/All-year-round Shelter
- ☐ Specialized shelter Beds
- ☐ Temporarily housing in a motel
- ☐ Board and Care
- ☐ Residential Treatment
- ☐ Transitional Housing
- ☐ Sober Living/Shared Housing
- ☐ Drug Tx Program
- ☐ Housing alone or with others
- ☐ Project Based Section 8 Housing
- ☐ Tenant based Section 8 Housing

Housing History Patterns

3. Describe client's living arrangements for the past five years:
(Include periods of homelessness, incarceration, hospitalization, shelter and residential programs, rehabilitation/detox centers)

Month(s)/Year(s)	Location