**COMMWELL HEALTH**

**SPNS ELIGIBILITY SCREENING FORM**

*Please answer the following questions regarding the participant’s eligibility for the SPNS program and multisite evaluation. This form should be completed for any client referred to the SPNS program.*

**TO BE COMPLETED BY CARE MANAGER, NAVIGATOR, or PROGRAM MANAGER:**

|  |  |  |
| --- | --- | --- |
| 1. | Is the person 18 years or older? | 🞏 NO 🞏 YES |
| 2. | Is the person HIV-positive? | 🞏 NO 🞏 YES |
| HOUSING STATUS: Is this person homeless or unstably housed, defined as one of the following: (Eligible if at least one “YES” response |
| 3. | Literally Homeless: lacks a fixed, regular, and adequate nighttime residence | 🞏 NO 🞏 YES |
|  | Unstably housed individual who: | 🞏 NO 🞏 YES |
| 4. | Has not had a lease, ownership interest, or occupancy agreement in permanent and stable housing with appropriate utilities. | 🞏 NO 🞏 YES |
| 5 | Has experienced persistent housing instability as measured by two moves or more during the preceding 60 days. | 🞏 NO 🞏 YES |
| Individual fleeing domestic violence who: |
| 6. | Is fleeing, or attempting to flee, domestic violence; has no other residence; and lacks the resources or support networks to obtain other permanent housing. | 🞏 NO 🞏 YES |
| CO-MORBIDITY: Is this person multiply diagnosed as: A person who is HIV-positive and who has been screened and determined to need treatment services for one or more of the following co-occurring illness: (Eligible if at least one “YES” response) |
| 7. | Mental Illness: within client’s lifetime, any illness that significantly interferes with the performance of major life activities, such as learning, working and communicating, including, but not limited to: anxiety disorders such as PTSD, and mood disorders such as major depression, bipolar disorder or dysthymia. | 🞏 NO 🞏 YES |
| 8. | Substance Use: within clients lifetime, any use of illicit drugs or the abuse of alcohol, prescription or over-the-counter drugs for purposes other than those for which they are indicated or in a manner or in quantities other than directed by a prescribing health care provider. | 🞏 NO 🞏 YES |
| **TO BE COMPLETED BY STUDY COORDINATOR:** |
| 9. | INFORMED CONSENT**:** Did the subject sign the consent form? | 🞏 NO 🞏 YES |
|  | **IF NOT CONSENTED, Specify reason(s): (Choose all that apply)** |  |
|  | Participants reasons: Discretion of study staff: |  |
|  | 🞏 Timing 🞏 Too tired |  |
|  | 🞏 Not interested/no wait 🞏 Too ill, physical health problem |  |
|  | 🞏 Personal problems 🞏 Too ill, mental health problem |  |
|  | 🞏 Questions too personal 🞏 Inappropriate behavior |  |
|  | 🞏 Too ill 🞏 Not comprehending questions |  |
|  | 🞏 Unknown 🞏 Incomprehensive responses |  |
|  | 🞏 Other 🞏 Too high/inebriated |  |
|  |  🞏 Other |  |
| Participant ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

***Please submit to Data Manager upon completion. Thanking you in advance.***

*This publication is part of a series of manuals that describe models of care that are included in the HRSA SPNS Initiative* Building a Medical Home for Multiply Diagnosed HIV-Positive Homeless Populations*.  Learn more at* <http://cahpp.org/project/medheart/models-of-care>