# Connecticut Department of Mental Health and Addiction Services

## SUPPORTIVE HOUSING ASSESSMENT FORM - DDaP

**PROVIDER CLIENT ID:** _____

**CLIENT NAME:** _____

**DATE FORM COMPLETED:** _____ / _____ / _____

| INTAKE TYPE |
|---|
| ☐ ADMISSION |
| ☐ FOLLOWUP |
| ☐ DISCHARGE |

**PERCENT HOMELESS PAST 3 YEARS:**
**(only required if INTAKE TYPE is ADMISSION)** **(Enter 0-100)** _____

**CONNECTION COMMUNITY BASED SERVICES: (Past 6 Months):** ***(check all that apply)***

| | |
|---|---|
| ☐ MENTAL HEALTH TREATMENT | ☐ SUBSTANCE ABUSE TREATMENT |
| ☐ EMPLOYMENT SERVICES | ☐ EDUCATIONAL SERVICES |
| ☐ VOLUNTEER SERVICES | ☐ HEALTH / MEDICAL SERVICES |

**PERCENT TIME WORKED IN PAST 6 MONTHS:** **(Enter 0-100)** _____

**CURRENT HOUSEHOLD INCOME:** **(Annual Income)** _____

**NUMBER OF DAYS JAIL / PRISON IN PAST 6 MONTHS :** **(Enter 0-183)** _____

**NUMBER OF DAYS RESIDENTIAL / INPATIENT PAST 6 MONTHS :** **(Enter 0-183)** _____

**NUMBER OF EMERGENCY ROOM VISITS IN THE PAST 6 MONTHS :** _____

**How Many Children Does the Tenant Have?** _____

**Number of Children under age 18 living with Tenant:** _____

**DISCHARGE REASON:** ***(check one box below)***

- ☐ DISAPPEARED
- ☐ EVICTION
- ☐ MOVED IN WITH FAMILY OR FRIENDS
- ☐ MOVED TO ANOTHER HOUSING PROGRAM (Section 8, RAP, etc.)
- ☐ NEEDED HIGHER LEVEL OF CARE (inpatient/residential/supervised apartments, etc.)