

# HOPWA-Tenant-Based Rental Assistance Housing and Employment Acuity Screening

Complete the tool below to assess and evaluate client acuity for HOPWA-TBRA assistance. Complete all questions by interviewing the client and selecting responses accordingly. Use the point value attached to the client response to determine the score for each question. Add all of the scores under "Housing" to determine a total housing acuity score and add all of the scores under "Employment" to determine a total employment acuity score.

- Clients with a housing acuity score of 17 – 24 and an employment acuity score of 6 – 8 are considered "intensive need";
- Clients with a housing acuity score of 9 - 16 and an employment acuity score of 4 - 5 are considered "moderate need";
- Clients with a housing acuity score of 0 – 8 and an employment acuity score of 0 - 3 are considered "basic need".

Submit, via secure email to [columbushousing@equitashealth.com](mailto:columbushousing@equitashealth.com), the completed Housing Acuity Screening, along with the client's most recent Ryan White Part A Eligibility Form or Ryan White Part B RWAD Application, page one. Incomplete forms may be returned to the referral source.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Referral Source Information

Name of Professional: \_\_\_\_\_ Agency Name: \_\_\_\_\_

Phone Number: (\_\_\_\_\_) \_\_\_\_\_ E-mail Address: \_\_\_\_\_

*By signing this form, I verify that all client eligibility information has been properly reviewed and documented per Columbus Public Health or Ohio Department of Health policy and that the client is approved to access Columbus Ryan White Part A or Ryan White Part B services.*

Signature of Referring Professional (required): \_\_\_\_\_

Client's Ryan White Part A Eligibility Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ NA

Client's Ryan White Part B Eligibility Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ NA

Central Ohio HIV Case Management Network Release Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Client Contact Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Client Acuity Screening

### Housing:

1. Over the past year, how would you describe your health?
2. Over the last year, how many times have you visited an emergency room?
3. Over the last year, how many times have you been admitted to the hospital?
4. How many diagnosed health conditions (current and/or long term) do you have?
5. Do you have any diagnosed mental health conditions?
6. In the past six months, where have you resided the most?
7. How would you best describe your current housing situation?
8. Over the last two years, how many times have you been homeless?

Total Housing Acuity Score: \_\_\_\_\_

Employment

9. Are you interested in working?

10. Are you interested in participating in education or training for career advancement?

11. Are you interested in working with a career consultant to set and work toward individualized employment goals?

12. Have you been told by a doctor/other healthcare professional that you cannot work?

If YES: 12a. For what duration of time? \_\_\_\_\_

Total Employment Acuity Score: \_\_\_\_\_

**OFFICE USE ONLY**

Acuity Screening Received: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Reviewer: \_\_\_\_\_

Was Information Missing?  Yes  No

Describe Missing Information/Interaction w/Referral Source: \_\_\_\_\_

Request for Missing Information: \_\_\_\_/\_\_\_\_/\_\_\_\_ Missing Information Received: \_\_\_\_/\_\_\_\_/\_\_\_\_

E-mail Confirmation of Receipt of Referral to Referral Source: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Determination:**

Request HOPWA-TBRA Referral  Waitlist  Denied, Does Not Meet Criteria

Explanation for Denial: \_\_\_\_\_  
\_\_\_\_\_