Shelter Screening Tool Questions

Name:		Date:
Sex: M F	Date of birth:	Phone:
Head of household: ☐ Self ☐ Other ☐ Service point number:		
Welcome! Please answer these questions to assure that you and others are healthy during your stay with us.		

Questions	Select One	Comments
Do you have any of the following?		
1. History of close contact with confirmed COVID-19 case within last 14 days? (close contact = within 6 feet for prolonged periods or sharing objects).	☐ Yes ☐ No	
1. Fever [subjective or actual with thermometer (≥100.4)]?	☐ Yes ☐ No	
2. Cough?	☐ Yes ☐ No	
3. Shortness of breath?	☐ Yes ☐ No	
If yes to #3 above, answer #5-7		
4. Have a cough for more than 2 weeks?	☐ Yes ☐ No	
5. Have severe coughing spasms?	☐ Yes ☐ No	
6. Has the person ever been told they have tuberculosis by a medical professional?	☐ Yes ☐ No	
All answer #8		
7. Rash or itchy skin?	☐ Yes ☐ No	
Ask #9 for females only		
8. Are you pregnant?	☐ Yes ☐ No	

Revised 4.3.2020

Supplemental Behavioral Health Two-Part Screening Questions for Temporary Lodging
Part One

The following question is related to substance use and does not impact your ability to access the shelter services, but will assist us in ensuring you have the services you need:	
1. How many days in the past year did you use alcohol, illicit substances or prescription medication other than as prescribed?	☐ None ☐ Monthly ☐ Weekly ☐ Daily

*The below questions are to be asked **after** you have been identified to be moved to a temporary lodging arrangement. The answers to the below questions are to assist in providing services and assistance you need, and will not impact access to temporary lodging.*

Questions	Select One	Comments
2. **Are you currently taking any mental health medications?** (Such as medications for mood, anxiety or to help with thoughts or voices)	☐ Yes ☐ No ☐ Maybe	
3. **Are you currently taking substance use medications** (such as methadone or buprenorphine)?	☐ Yes ☐ No ☐ Maybe	

Part Two: COLUMBIA-SUICIDE SEVERITY RATING SCALE

	Past month	
	YES	NO
1. Have you wished you were dead or wished you could go to sleep and not wake up?	☐	☐
2. Have you actually had any thoughts of killing yourself? *(If yes to 2, answer 3, 4, 5, and 6; If No, go directly to question 6.).*	☐	☐
3. Have you been thinking about how you might kill yourself?	☐	☐
4. Have you had these thoughts and had some intention of acting on them?	☐	☐
5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?	☐	☐
6. Have you ever done anything, started to do anything, or prepared to do anything to end your life? If yes, how long ago did you do any of these? • Over one year ago? • Between three months and a year ago? • Within the last three months?	☐	☐