



Bridge Housing Eligibility and Prioritization System (BHEPS)





Who should use this form?

This form is to refer individuals into the Behavioral Health Bridge Housing program who are experiencing homelessness and have behavioral health needs.

What to do:

- ✓ Ensure the client meets eligibility criteria, prior to submitting form.
- ✓ Fill out all required fields (marked with a *)
- ✓ Ensure all areas of the form have been completed. Incomplete forms will be rejected.
- ✓ Ensure all fields have been totaled, accurately.
- ✓ Submit completed form via secure email to: DHS-BHS-BHBHreferral@saccounty.gov

Definitions:

Literally Homeless – Chronic

- ✓ The individual has a disability AND
- ✓ Individuals have been homeless for 12+ consecutive months, OR
- ✓ Individuals have had 4+ episodes of homelessness totaling 12 months over the last 3 years

Literally Homeless – Non-Chronic

- ✓ The individual is currently unsheltered (e.g., street, car, tent, etc.),
- ✓ **But** does not meet the chronic duration requirement
- ✓ Fleeing Violence or Danger
- ✓ Escaping domestic violence, human trafficking, or another dangerous situation
- ✓ Has no safe alternative housing and lacks resources/support to obtain it

Bridge Housing Eligibility and Prioritization System (BHEPS)				
Referring Party Information				
Referrer's Name*:	Agency:	Program:		
Phone Number:	Email:	Referral Type*: <input type="checkbox"/> New <input type="checkbox"/> Update <input type="checkbox"/> Renewal (120+ days of absence) Preferred Contact Method? <input type="checkbox"/> Phone <input type="checkbox"/> Email		
Client Information				
Client Legal Name*:	Preferred/Alias/Nickname:	Screening Date*:		
Date of Birth*:	Phone:	May we contact client? <input type="checkbox"/> Yes <input type="checkbox"/> No		
HMIS ID (if available):	SmartCare Number (if available):	Preferred Language*:		
Condition of referral*(Select all that apply): <input type="checkbox"/> Literally Homeless - Chronic: living on the street, in a park, car, tent, etc. <input type="checkbox"/> Literally Homeless – Non-Chronic: living on the street, in park, car, tent, etc. <input type="checkbox"/> CARE Court Referral <input type="checkbox"/> Jail – will exit into homelessness <input type="checkbox"/> Hospital – will exit into homelessness <input type="checkbox"/> Client is housed, sheltered, staying in a hotel, or sleeping on someone's couch/floor - STOP CLIENT IS INELIGIBLE				
Client's last known location (cross streets or facility name):				
*Required				
Client MUST meet all 4 factors below to be eligible for this independent living environment*(Check ALL that apply): <input type="checkbox"/> Client does NOT require nursing level medical needs <input type="checkbox"/> Client agrees to participate in behavioral health treatment - IF NO, STOP CLIENT IS INELIGIBLE <input type="checkbox"/> Client can manage their own medications <input type="checkbox"/> Client can perform Activities of Daily Living (ADLs)** <div style="text-align: center; font-size: small;">**Client is independent with mobility, hygiene, housekeeping, laundry, and basic meals.</div>				
*All boxes must be checked, if not, STOP client is ineligible				
1. History of Mental Health/SUD	4 points	3 points	2 points	1 point
a. Highest Intensity of Mental Health and/or Substance Use Disorder (SUD) Treatment Outpatient Services Received (within last 10 years) <input type="checkbox"/> No History of outpatient services	<input type="checkbox"/> High-Intensity Services <i>(Received or receiving Full-Service Partnership, SUD Intensive Outpatient Services or Alta Regional services in the past year.)</i>	<input type="checkbox"/> Moderate Services <i>(Received or receiving moderate intensity- level CORE mental health services or Outpatient SUD Treatment.)</i>	<input type="checkbox"/> Managed Care Plan <i>(Received or receiving mental health or SUD treatment services through a managed care plan. (Kaiser, Anthem, Molina, etc.)</i>	<input type="checkbox"/> Peer- driven groups or self-help group <i>(e.g., Alcoholics Anonymous, Narcotics Anonymous)</i>
* Required field – This field must be completed. Incomplete forms will not be accepted.				
2. Chronicity Status	4 points	3 points	2 points	1 point
a. Homeless History and Urgent Safety Needs <i>Homeless:</i> <ul style="list-style-type: none"> A person or family is considered homeless if they don't have a safe, stable place to sleep at night. This can include: <ul style="list-style-type: none"> Sleeping outside, in a car, or in a place not meant for people to live (does not include couch surfing) Staying in an emergency shelter or transitional housing Escaping domestic violence and having no safe housing options 	<input type="checkbox"/> Chronic-12 or more consecutive months in a row OR <input type="checkbox"/> 4 separate occasions totaling 12 months over the past 3 years	<input type="checkbox"/> Literally Homeless 9-12 months OR <input type="checkbox"/> Fleeing violence or danger, with no safe housing or resources available.	<input type="checkbox"/> Homeless 3–9 months	<input type="checkbox"/> Homeless less than 3 months
b. Number of Episodes of Literal Homelessness in Last 3 Years	<input type="checkbox"/> 6 or more episodes OR <input type="checkbox"/> Homeless 1+ year in one episode	<input type="checkbox"/> 4-5 episodes	<input type="checkbox"/> 2-3 episodes	<input type="checkbox"/> 1* episode
Total Score for Section:				
*Choose only one box in each subsection.				

3. Risk Factors	4 points	3 points	2 points	1 point
a. Psychiatric Hospitalizations: <input type="checkbox"/> No History	<input type="checkbox"/> Currently hospitalized or 2+ times in past year	<input type="checkbox"/> Once within last year	<input type="checkbox"/> Over a year ago	<input type="checkbox"/> Over 3-5 years ago
b. Abuse: Community Violence, Domestic Violence (DV), Abuse, or Commercial Sexual Exploitation without access to natural resources <input type="checkbox"/> No History	<input type="checkbox"/> Currently escaping abuse <i>(e.g., DV agency referral, protective order, injuries, etc.)</i>	<input type="checkbox"/> History of DV or abuse within the last 3 months <i>(recent incidents, healing injuries, using DV services, etc.)</i>	<input type="checkbox"/> History of DV or abuse within 4-12 months.	<input type="checkbox"/> History of DV or abuse over 1+ years
c. Danger to Others (DTO): <i>(Including stalking and intent)</i> <input type="checkbox"/> Not Applicable	<input type="checkbox"/> Threats or acts of violence with means in the past month	<input type="checkbox"/> Threats or acts of violence with means within the past 3 months	<input type="checkbox"/> Threats or acts of violence with means within the past 6 months	<input type="checkbox"/> Threats or acts of violence with means within the past 12 months
d. Justice Involved: <input type="checkbox"/> No History	<input type="checkbox"/> Released from Jail/Prison within the last 30 days or awaiting sentencing	<input type="checkbox"/> CURRENTLY on Probation or Parole	<input type="checkbox"/> Released from Jail/Prison <i>(within the last 365 days)</i>	<input type="checkbox"/> 1+ years ago <i>(not on probation or parole)</i>
e. Substance Use: <input type="checkbox"/> No History	<input type="checkbox"/> Current, severe <i>(Daily symptoms with moderate to severe impact on functioning and/or involvement with legal issues, life threatening withdrawal symptoms, etc.)</i>	<input type="checkbox"/> Current, moderate <i>(Uses 3-4 days per week or recently relapsed, with mild to moderate impact on functioning)</i>	<input type="checkbox"/> Current, minimal <i>(Recreational/minimal impact on functioning, though may experience personal challenges)</i>	<input type="checkbox"/> In recovery <i>(past use, not currently using)</i>
f. Psychiatric Medication: <input type="checkbox"/> No History	<input type="checkbox"/> Does not take medications as directed leading to negative effects <i>(Currently/recently prescribed medications)</i>	<input type="checkbox"/> Current or recent prescription <i>(Medications have been lost, stolen, or unfilled)</i>	<input type="checkbox"/> Previously prescribed <i>(Has not seen the doctor in 6+ months)</i>	<input type="checkbox"/> Currently stable on prescription
g. Danger to Self/Suicide History: <input type="checkbox"/> No History	<input type="checkbox"/> Within 3 months <i>(History of Suicide attempt and/or suicidal ideation with plan, method, and intent. Or recent discharge from psychiatric hospital.)</i>	<input type="checkbox"/> Within 6 months <i>(With 2 of 3 elements: plan, method or intent)</i>	<input type="checkbox"/> Within 1 year <i>(with 1 of 3 elements: plan, method, or intent)</i>	<input type="checkbox"/> More than 1 year <i>(With history of suicide attempt/suicidal ideation)</i>
Alert: If client has current S/I with means, plan and intent, immediately provide crisis intervention (Mental Health Urgent Care Clinic, 988, 911, etc.)				

3. Risk Factors (Cont.)	4 points	3 points	2 points	1 point
h. Daily Functioning: <input type="checkbox"/> No History <i>This may include:</i> 1. Emotional: frequent outbursts, anger, crying, struggles with anxiety and depression affecting employment/education, significant risk taking 2. Cognitive: Difficulty concentrating, poor memory, difficulty understanding info, problem solving, hallucinations 3. Self-Care that regularly requires medical intervention or exacerbates a medical condition: poor hygiene, poor nutrition, high medical needs 4. Relationships: Isolation, alienates natural support system, difficulty communicating 5. Struggled to maintain housing in recent past or has been homeless	<input type="checkbox"/> Significant impairment <i>(4-5+ areas affected)</i>	<input type="checkbox"/> Moderate impairment <i>(3-4 areas affected)</i>	<input type="checkbox"/> Mild impairment <i>(2+ areas affected)</i>	<input type="checkbox"/> Potential impairment <i>(1 area affected)</i>
i. Support system: <input type="checkbox"/> No Needs <i>Accesses a support system that provide emotional, psychological, and practical help for the individual. Includes service agencies.</i>	<input type="checkbox"/> Support potentially needed	<input type="checkbox"/> Limited supports	<input type="checkbox"/> Minimal supports	<input type="checkbox"/> Highly supported
j. Medical co-morbidity: <input type="checkbox"/> No Needs <i>The presence of one or more additional diseases or conditions occurring at the same time as SMI/SUD</i>	<input type="checkbox"/> Serious medical needs requiring regular care <i>(e.g., diabetes, cancer, daily life saving meds)</i>	<input type="checkbox"/> Occasional care or meds needed <i>(Long-term impact if left untreated)</i>	<input type="checkbox"/> Medical needs present but has no impact on daily function	<input type="checkbox"/> Has not seen a doctor to assess need
k. Medical equipment: <input type="checkbox"/> Not Applicable	<input type="checkbox"/> Requires electric equipment or refrigerated medication <i>(e.g., CPAP, insulin)</i>	<input type="checkbox"/> Needs equipment for medical monitoring <i>(e.g., wound care, testing supplies)</i>	<input type="checkbox"/> Needs ADA-related equipment <i>(e.g., wheelchair/walker)</i>	<input type="checkbox"/> Other <i>(Please explain):</i> <hr/> <hr/> <hr/> <hr/>
Total Score for Section:				
<i>*Choose only one box in each subsection.</i>				
4. Barriers	4 points	3 points	2 points	1 point
a. Income: <input type="checkbox"/> No Income	<input type="checkbox"/> No Income	<input type="checkbox"/> Cash Aid or Social Security <i>(Cannot afford rent, rent subsidized or needs additional support)</i>	<input type="checkbox"/> Regular income <i>(Cannot afford rent, rent subsidized or needs additional support)</i>	<input type="checkbox"/> Other <i>(Please explain):</i> <hr/> <hr/> <hr/> <hr/>
b. Rental History in the last 7 years: <input type="checkbox"/> Fair/Good rental history	<input type="checkbox"/> 2+ evictions	<input type="checkbox"/> 1 eviction	<input type="checkbox"/> Poor rental history	<input type="checkbox"/> No rental history

4.Barriers (Cont.)	4 points	3 points	2 points	1 point
c. Protective System involvement History <input type="checkbox"/> No Involvement	<input type="checkbox"/> Current/recent Child Protective Services (CPS) or Adult Protective Services (APS) involvement	<input type="checkbox"/> CPS or APS involvement 1- 2 years ago	<input type="checkbox"/> Involvement over 2 years ago	<input type="checkbox"/> Involvement 5+ years ago
d. Employment: <input type="checkbox"/> Full-Time Employment	<input type="checkbox"/> Unemployed 12months or more	<input type="checkbox"/> Unemployed 6-12 months	<input type="checkbox"/> Unemployed 0-6 months	<input type="checkbox"/> Part-time or underemployed (Less than 32 hours a week)
Total Score for Section:				
<i>*Choose only one box in each subsection.</i>				
5. Special Populations <i>(Check all applicable boxes) 1 point each</i>				
<input type="checkbox"/> Older adults (55+)		<input type="checkbox"/> Pregnant		
<input type="checkbox"/> System involved (APS/CPS)		<input type="checkbox"/> Foster Youth aging out or non-minor dependents		
Total Score for Section:				
<i>*Choose only one box in each subsection.</i>				
Additional Information or details on client to help determine eligibility: <hr/> <hr/> <hr/>				
Total Score for Sections 1–5:				
<i>Please total the score from each section (1 through 5) and enter the combined total above.</i>				
6. Additional Information (these will not affect scoring and will be used for matching to appropriate options) <i>(Check all applicable boxes)</i>				
<input type="checkbox"/> Not Applicable <input type="checkbox"/> ADA Needs (i.e. wheelchair, walker, etc.) Please Describe: <input type="checkbox"/> Single cabin <input type="checkbox"/> Double cabin (is the partner BHBH Eligible: list name and HMIS number of partner if known: _____)		Vehicle <input type="checkbox"/> Operational (Registered and insured, current driver's license) <input type="checkbox"/> Non-operational <input type="checkbox"/> No vehicle	Felony Conviction: <input type="checkbox"/> Not Applicable <input type="checkbox"/> Drug felony <input type="checkbox"/> Arson <input type="checkbox"/> 290 Registrant <input type="checkbox"/> Violent <input type="checkbox"/> Other (Please explain): _____	
Other Important Information: <input type="checkbox"/> Not Applicable <input type="checkbox"/> Chronic health issues. Please Describe: <hr/> <hr/>		Pets: <input type="checkbox"/> None <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Other (describe): _____ Total number of pets: _____ <i>Pet Policy: Up to 2 pets total allowed — either 1 dog (maximum 25 lbs.) or 2 small pets with a combined weight under 25 lbs.</i>		
Has the client had any previous Sacramento County or out-of-county shelter stays? <i>If yes, please list the location(s):</i> _____				
Completed BHEPS can be sent via SECURE email to: DHS-BHS-BHBHreferral@sacounty.gov				
<p>A BHBH clinician will review referrals and may reach out to the referring party for more information to determine eligibility for a BHBH bed based on the score and other criteria. The team will then communicate the decision. Submitting this referral form does not guarantee a BHBH bed or placement on the waitlist if eligibility criteria are not met.</p> <p>Please be aware that each shelter has its own set of program rules. These may include but are not limited to: prohibitions on illicit substances, availability of amnesty lockers, and requirements for background checks.</p> <p>This screener is for the BHBH program only. For immediate shelter openings in other areas at other community shelters, contact Sacramento 211 by dialing 2-1-1.</p>				