Please answer all questions and fill in all information. Your answers will help us understand your health conditions and needs. Tell your homeless coordinator if you need help with this form. They can read the form to you or answer your questions.

Head of Household or Main Caregiver

First Name

Middle Name (if Applicable)

Last Name

Today's Date (Month/Day/Year)

Birth Date (Month/Day/Year)

Health Assessment

What is your youngest child's date of birth? (Month/Day/Year)

◯ I don't have any children

Is the primary caregiver over the age of 70?

◯ Yes ◯ No

Is anyone in your family pregnant?

◯ Yes ◯ No ◯ I do not know

If yes, please answer these questions:

How many weeks pregnant is this person?

If you don't know the number of weeks, tell us the date of last menstrual period or when they are due

Have they been told that their pregnancy is high-risk?

◯ Yes ◯ No ◯ I do not know

Does anyone in your family take medicine that needs to stay cold or be kept in the refrigerator?

◯ Yes ◯ No ◯ I do not know

Do you have a family member who needs special medical equipment to help them with everyday things? These may be eating, breathing, or drinking.

◯ Yes ◯ No ◯ I do not know

Do you have a family member who has a weak immune system (they are immunocompromised)? This may mean that they:

- Get chemotherapy treatment for cancer
- Have untreated HIV/AIDS
- Have Sickle Cell Disease
- Take medicine for an organ transplant

◯ Yes ◯ No ◯ I do not know

Do you have a family member with 3 or more chronic medical conditions? These may be diabetes, high blood pressure, asthma, heart disease, severe mental illness, substance use disorder or others.

◯ Yes ◯ No ◯ I do not know

Massachusetts Executive Office
of Housing and Livable Communities
DIVISION OF HOUSING STABILIZATION

Prioritization Screening Questionnaire

For Administrative Use Only

Today's Date (Month/Day/Year)

First Name

Middle Name (if Applicable)

Last Name

Birth Date (Month/Day/Year)

1. Infant(s) under 9 months of age

◯ Yes ◯ No

2. Primary caregiver over 70 years of age

◯ Yes ◯ No

3. Pregnant person in third trimester (28 weeks or greater gestation) or high-risk pregnancy

◯ Yes ◯ No

4. Household member with chronic medical condition treated with a medication requiring refrigeration

◯ Yes ◯ No

5. Household member that needs special medical equipment to help them with everyday things, such as eating, breathing, or drinking

◯ Yes ◯ No

6. Household member with an immunocompromising condition, including but not limited to sickle cell disease, untreated HIV or active chemotherapy administration

◯ Yes ◯ No

7. Household member with at least three chronic conditions, including but not limited to diabetes, serious mental health condition, high blood pressure or asthma

◯ Yes ◯ No