**Eviction Prevention and Intervention Coalition Screening Tool**

**Courtroom/Judge:**

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| **Section A****Client Profile:**  |
| Client Full Name: | Head of Household | Other Adult Household Member (if applicable) |
|  |  |
| Date of Birth: |  |  |
| Social Security #: |  |  |
| Gender: |  |  |
| Race/Ethnicity: |  |  |
| Phone#:  |  |  |
| Email:  |  |  |
| Medical Assistance#: (If applicable)  |  | Obtained a copy of client’s Access Card?  |
| **Household Income: Average total household income over the last 90 days**  |
| Monthly Net Income: |   |
| Monthly Gross Income: |  |
| Household Size:  |  | Number of Children (under 18):  |
| % Area Median Income (AMI):  |  |
| **Eviction Hearing Information:**  |
| Reason for eviction hearing:  | * Nonpayment of Rent
 | * Lease Violation
 | Other:  |
| Do you have your lease with you today?  | Lease Date:  | Describe any other documents or evidence with you today:  |
| Landlord Information:  | Type of Landlord:  | * Private
 | * Property Manager/Business
 | * Housing Authority
 | * Other:
 |
| Name: |
| Address: |
| Email: |
| Phone Number:  |
| Complete the appropriate section based on reason for eviction |
| a. Eviction due to nonpayment of rent | Monthly rent: |
| Total amount due: |
| Late/filing fees included: |
| Amount tenant can pay:  |
| Client’s explanation for reason of nonpayment: |
| b. Eviction due to violation of lease agreement  | Describe and include any fee(s): |
| Potential counterclaims:  |
| c. Vulnerable Populations (Children under 5, domestic violence, seniors, veterans, etc…  | Describe: |
| Potential counterclaims:  |
| **Section B****Social Service Screening Determination:** |
| Eligible for Financial Assistance: | * Yes
 |
| * No

Reason for Ineligibility:  |
| Recommend Financial Assistance:  |  | Follow Up Date: |  |
| Case Management Referrals: |  | Follow Up Date: |  |
|  | Follow Up Date: |  |
|  | Follow Up Date: |  |
|  | Follow Up Date: |  |
|  | Follow Up Date: |  |
| **Section C****Attorney Screening Determination:** |
| Attorney Name:  |  | Date: |  |
| Attorney Contact Information:  |  |
| Eligible for Representation:  | Next Steps:  |
| Not Eligible for Representation:  | Reason for non-representation:* Provided with self-representation materials
 |

**For Office Use:**

|  |  |
| --- | --- |
| **Household at or below 60% AMI: Yes No** | **Health Choices Eligibility****Household at or below 50% AMI: Yes No** |
| **EPIC Specialist Name:**  |
| **Manager Name:** |  | **Approval Date:** |  | **Manager Signature:** |  |
| **Notes:**  |