

**VCRHYP BCP SWITCH FORM**  
**To switch youth from Prevention into Shelter**

<b>CLIENT RECORD</b>	
Client ID # from HMIS:	
Name of youth care worker:	
Agency name:	
Date of switch:	
<p>Where were you staying the night before entering BCP Shelter?</p> <p><b>(Response should be where the youth was the NIGHT PRIOR to going into shelter)</b></p>	<p><b>1. Homeless Situation *ask follow-up questions in SECTION 1 below (pg. 2)</b></p> <p><input type="checkbox"/> Place not meant for habitation (<i>e.g. vehicle, abandoned building, bus/train/subway station, airport, or anywhere outside</i>)</p> <p><input type="checkbox"/> Emergency shelter, including hotel or motel paid for WITH an emergency shelter voucher or a BCP shelter/host home bed</p> <p><b>2. Institutional Situation or Temporary/ Permanent Housing *ask follow-up questions in SECTION 2 (pg. 2)</b></p> <p><input type="checkbox"/> Foster care home or foster care group home</p> <p><input type="checkbox"/> Hospital or other residential non-psychiatric medical facility</p> <p><input type="checkbox"/> Jail, prison, or juvenile detention facility</p> <p><input type="checkbox"/> Long-term care facility or nursing home</p> <p><input type="checkbox"/> Psychiatric hospital or other psychiatric facility</p> <p><input type="checkbox"/> Substance abuse treatment facility or detox center</p> <p><input type="checkbox"/> Hotel or motel paid for WITHOUT emergency shelter voucher</p> <p><input type="checkbox"/> Non-crisis host home (<i>this does NOT include BCP or TLP host homes</i>)</p> <p><input type="checkbox"/> Owned by client, NO ongoing housing subsidy</p> <p><input type="checkbox"/> Owned by client, WITH ongoing housing subsidy</p> <p><input type="checkbox"/> Permanent housing for formerly homeless persons (other than RRH)</p> <p><input type="checkbox"/> Rental by client in public housing of a housing authority</p> <p><input type="checkbox"/> Rental by client, NO ongoing housing subsidy</p> <p><input type="checkbox"/> Rental by client, with RRH or equivalent subsidy</p> <p><input type="checkbox"/> Rental by client, with GDP TIP housing subsidy (<b>Veterans only</b>)</p> <p><input type="checkbox"/> Rental by client, with other ongoing housing subsidy</p> <p><input type="checkbox"/> Rental by client, with Housing Choice (Section 8) voucher (<i>tenant or project based</i>)</p> <p><input type="checkbox"/> Rental by client, with VASH housing subsidy (<b>Veterans only</b>)</p> <p><input type="checkbox"/> Residential project or halfway house with no homeless criteria</p> <p><input type="checkbox"/> Staying or living in a family member's room, apartment, or house</p> <p><input type="checkbox"/> Staying or living in a friend's room, apartment, or house</p> <p><input type="checkbox"/> Transitional housing for homeless persons (including youth)</p> <p><b>Other *skip to Domestic Violence section on pg. 2</b></p> <p><input type="checkbox"/> Client doesn't know</p> <p><input type="checkbox"/> Client refused</p> <p><input type="checkbox"/> Data not collected</p>

## SECTION 1. YOUTH WAS IN A HOMELESS SITUATION BEFORE BCP SHELTER

How long were you staying there?	<input type="checkbox"/> 1 night or less <input type="checkbox"/> 2-6 nights <input type="checkbox"/> 1 week or more, but less than 1 month <input type="checkbox"/> 1 month or more, but less than 90 days <input type="checkbox"/> More than 90 days, but less than 1 year	<input type="checkbox"/> 1 year or longer <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
When did you start staying on the streets or in emergency shelter? (mm/dd/yyyy)	<b>Ask the youth to think back to the last time they had a place to sleep that <u>wasn't</u> on the streets/ an emergency shelter, then enter the <u>day after</u> that here:</b>	
How many times have you been on the streets/ in emergency shelter in the past 3 years (including today)?	<input type="checkbox"/> One time <input type="checkbox"/> Two times <input type="checkbox"/> Three times <input type="checkbox"/> Four or more times	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
How many months were you on the streets/ in emergency shelter in the past 3 years?	<input type="checkbox"/> One month ( <i>this is the first time</i> ) <input type="checkbox"/> 2-12 months - <b>Specify #:</b> _____ <input type="checkbox"/> More than 12 months	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

## SECTION 2. YOUTH WAS IN AN INSTITUTIONAL SITUATION OR TEMPORARY/ PERMANENT HOUSING BEFORE BCP SHELTER

How long were you staying there?	<input type="checkbox"/> 1 night or less <input type="checkbox"/> 2-6 nights <input type="checkbox"/> 1 week or more, but less than 1 month <input type="checkbox"/> 1 month or more, but less than 90 days <input type="checkbox"/> More than 90 days, but less than 1 year	<input type="checkbox"/> 1 year or longer <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
How many times have you been on the streets/ in emergency shelter in the past 3 years (including today)?	<input type="checkbox"/> One time <input type="checkbox"/> Two times <input type="checkbox"/> Three times <input type="checkbox"/> Four or more times	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
How many months were you on the streets/ in emergency shelter in the past 3 years?	<input type="checkbox"/> One month ( <i>this is the first time</i> ) <input type="checkbox"/> 2-12 months - <b>Specify #:</b> _____ <input type="checkbox"/> More than 12 months	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

## DOMESTIC VIOLENCE

Has a partner or someone you were living with ever made you feel afraid for your safety, hurt you, or controlled your choices?	<input type="checkbox"/> Yes <b>*continue below</b> <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>IF YES, CONTINUE WITH SECTION BELOW</b>		
When did you have this experience?	<input type="checkbox"/> Within the past 3 months <input type="checkbox"/> 3-6 months ago <input type="checkbox"/> 6-12 months ago <input type="checkbox"/> 1 year ago or more	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Are you currently fleeing, attempting to flee, or afraid to return to where you are staying?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

DISABILITIES		
Have there been any updates to your disability status?	<input type="checkbox"/> Yes <b>*complete Disability Addendum on pg. 8</b>	<input type="checkbox"/> No

HEALTH INSURANCE		
Do you have health insurance?	<input type="checkbox"/> Yes <b>*specify below</b> <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<i>If yes, which of the following types of health insurance do you have?</i>  <b>(Check all that apply)</b>	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> State children's health ins. (Dr. Dynasaur) <input type="checkbox"/> VA medical services <input type="checkbox"/> Employer-provided (including TRICARE)	<input type="checkbox"/> COBRA <input type="checkbox"/> Private pay <input type="checkbox"/> State health ins. for adults <input type="checkbox"/> Indian health services <input type="checkbox"/> Other- <b>Specify:</b> _____ <input type="checkbox"/> Data not collected

CHILD'S HEALTH INFORMATION – Skip if youth is not parenting		
Does your child have any of the following types of health insurance?  <b>(Check all that apply)</b>	<input type="checkbox"/> None <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> State children's health ins. (Dr. Dynasaur) <input type="checkbox"/> VA medical services <input type="checkbox"/> Employer-provided (including TRICARE)	<input type="checkbox"/> COBRA <input type="checkbox"/> Private pay <input type="checkbox"/> Indian health services <input type="checkbox"/> Other- <b>Specify:</b> _____ <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Have there been any updates to your child's disability status?	<input type="checkbox"/> Yes <b>*complete Child Disability Addendum on pg. 9</b>	<input type="checkbox"/> No

NON-CASH BENEFITS		
Do you receive non-cash benefits from any source? <b>(Select yes if the youth receives the benefit directly or if someone in their household receives it on their behalf)</b>	<input type="checkbox"/> Yes <b>*specify below</b> <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<i>If yes, which of the following types of non-cash benefits do you receive?</i>  <b>(Check all that apply)</b>	<input type="checkbox"/> SNAP (3SquaresVT/food stamps) <input type="checkbox"/> WIC <input type="checkbox"/> TANF (Reach Up) child care services <input type="checkbox"/> TANF (Reach Up) transportation services	<input type="checkbox"/> Other TANF (Reach Up) services <input type="checkbox"/> Other source- <b>Specify:</b> _____ <input type="checkbox"/> Data not collected

RHY SPECIFIC DATA		
BCP only - Youth care worker: Is youth a runaway?	<input type="checkbox"/> Yes ( <i>youth under 18 years of age who absents themselves from home/place of legal residence without the permission of a parent/legal guardian</i> )	<input type="checkbox"/> No <input type="checkbox"/> Worker doesn't know <input type="checkbox"/> Data not collected
What is your sexual orientation?	<input type="checkbox"/> Heterosexual <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Questioning/Unsure	<input type="checkbox"/> Other – <b>Please describe:</b> <hr/> <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
What was the last grade you completed in school?	<input type="checkbox"/> Less than grade 5 <input type="checkbox"/> Grades 5-6 <input type="checkbox"/> Grades 7-8 <input type="checkbox"/> Grades 9-11 <input type="checkbox"/> Grade 12/high school diploma <input type="checkbox"/> School program does not have grade levels <input type="checkbox"/> GED	<input type="checkbox"/> Some college <input type="checkbox"/> Associate's degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Graduate degree <input type="checkbox"/> Vocational certification <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
What is your current school status?	<input type="checkbox"/> Attending school regularly ( <i>without extended absenteeism</i> ) <input type="checkbox"/> Attending school irregularly ( <i>1-3 days/week on average</i> ) <input type="checkbox"/> Graduated from high school <input type="checkbox"/> Obtained GED	<input type="checkbox"/> Dropped out <input type="checkbox"/> Suspended <input type="checkbox"/> Expelled <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Are you employed?	<input type="checkbox"/> Yes <b>*ask follow-up question</b> <input type="checkbox"/> No <b>*ask follow-up question</b>	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>If employed, what type of employment is it?</b>	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Seasonal/sporadic ( <i>including day labor</i> ) <input type="checkbox"/> Data not collected
<b>If not employed, why not?</b>	<input type="checkbox"/> Looking for work <input type="checkbox"/> Unable to work ( <i>due to a physical/developmental disability or illness</i> )	<input type="checkbox"/> Not looking for work <input type="checkbox"/> Data not collected
How would you rate your general health status?	<input type="checkbox"/> Excellent <input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> Fair	<input type="checkbox"/> Poor <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Have you had an annual check-up with a doctor within the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
How would you rate your dental health status?	<input type="checkbox"/> Excellent <input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> Fair	<input type="checkbox"/> Poor <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Have you been to the dentist in the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

How would you rate your mental health status?	<input type="checkbox"/> Excellent <input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> Fair	<input type="checkbox"/> Poor <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Are you pregnant?	<input type="checkbox"/> Yes <b>*ask next question</b> <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<i>If yes, what is your due date?</i>		
Is your partner pregnant?	<input type="checkbox"/> Yes <b>*ask next question</b> <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<i>If yes, what is their due date?</i>		
Do you have any children?	<input type="checkbox"/> Yes <b>*ask next question</b> <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<i>If yes, do you have custody of your children?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Are you currently involved with DCF?	<input type="checkbox"/> Yes <b>*ask next question</b> <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<i>If yes, what is your current DCF involvement?</i>  <b>(Check all that apply)</b>	<input type="checkbox"/> Open DCF investigation <input type="checkbox"/> In DCF custody <input type="checkbox"/> Conditional custody order <input type="checkbox"/> Open family case with DCF <input type="checkbox"/> On juvenile probation	<input type="checkbox"/> Youthful offender status <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Are you currently involved with the <u>adult</u> criminal justice system? <i>(Drug Court, Parole, Community Service, Probation, etc.)</i>	<input type="checkbox"/> Yes <b>*ask name of officer -&gt;</b> <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected	<b><i>What is the name of your probation/parole officer/etc.?</i></b>  <b><i>What is their contact info?</i></b>
Are you subject to or protected by any of the following legal orders? <b>("Yes" responses indicate need for further discussion about safety and safety planning, as appropriate)</b>	<b>Check all that apply:</b> <input type="checkbox"/> None <input type="checkbox"/> Relief from abuse order <input type="checkbox"/> Stalking or sexual assault protection order <input type="checkbox"/> No contact order	<input type="checkbox"/> Other legal order <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Comments/notes:		
Are you currently working with any of the following programs?  <b>(These may be called something else in your community; use actual program names if possible)</b>	<b>Check all that apply:</b> <input type="checkbox"/> None <input type="checkbox"/> Balanced and Restorative Justice (BARJ) <input type="checkbox"/> Court Diversion <input type="checkbox"/> YHDP Project – <b>Specify:</b> <input type="checkbox"/> RRH <input type="checkbox"/> TH-RRH Joint Component <input type="checkbox"/> Diversion <input type="checkbox"/> Housing Navigation	<input type="checkbox"/> Youth in Transition (YIT) <input type="checkbox"/> Youth Development Program (YDP) <input type="checkbox"/> Prevention & Stabilization Services for Youth/Families (PSSYF) <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

<b>ARE ANY OF THE FOLLOWING CRITICAL ISSUES FOR YOU? (as identified by youth or staff)</b>		
Unemployment – family member	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Mental health issues – family member	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Physical disability – family member	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Alcohol or other substance abuse – family member	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Insufficient income to support youth <i>(parents/guardians have insufficient income to support youth's basic needs)</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Incarcerated parent of youth	<input type="checkbox"/> No	<input type="checkbox"/> Yes

<b>SEXUAL EXPLOITATION/TRAFFICKING</b>		
Have you ever received anything in exchange for having sexual contact with another person (such as money, food, drugs, or shelter)?	<input type="checkbox"/> Yes <b>*continue below</b> <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>IF YES, CONTINUE WITH SECTION BELOW</b>		
<i>Has this happened in the past 3 months?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<i>How many times have you received something in exchange for having sexual contact with another person?</i>	<input type="checkbox"/> 1-3 <input type="checkbox"/> 4-7 <input type="checkbox"/> 8-11 <input type="checkbox"/> 12 or more	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<i>Has someone ever made you or persuaded you to have sexual contact with anyone else in exchange for something?</i>	<input type="checkbox"/> Yes <b>*ask next question</b> <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<i>If yes, has this happened in the past 3 months?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

<b>WORKPLACE EXPLOITATION/LABOR TRAFFICKING</b>		
Have you ever been afraid to quit/leave a work situation due to fears of violence or other threats of harm to yourself/ family/ friends?	<input type="checkbox"/> Yes <b>*ask next 3 questions</b> <input type="checkbox"/> No <b>*ask next question</b>	<input type="checkbox"/> Client doesn't know <b>*ask next question</b> <input type="checkbox"/> Client refused <b>*ask next question</b> <input type="checkbox"/> Data not collected
Have you ever been promised work where the work or payment ended up being different from what you expected?	<input type="checkbox"/> Yes <b>*continue below</b> <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>IF YES TO EITHER OF THE PREVIOUS 2 QUESTIONS, CONTINUE WITH SECTION BELOW</b>		
<i>Did you feel forced, pressured, or tricked into continuing the job?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<i>Have you had any jobs like these in the last 3 months?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

## SAFETY & PERMANENT CONNECTIONS

Does the youth consider BCP Shelter to be safe?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Does the youth have permanent positive adult connections outside of the program?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Youth care worker doesn't know
Does the youth have permanent positive peer connections outside of the program?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Youth care worker doesn't know
Does the youth have permanent positive community connections outside of the program?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Youth care worker doesn't know

## COUNSELING

Did the youth receive counseling while in <b>BCP Prevention</b> ? <i>(counseling is defined as: the provision of guidance, support, referrals for services, and advice to youth and their families designed to alleviate the problems that have put the youth at risk of running away or contributed to their running away or being homeless)</i>	<input type="checkbox"/> Yes <b>*continue below</b> <input type="checkbox"/> No <b>* should only be selected if youth was in BCP Prevention for such a short time that no case management sessions occurred</b>
<b>IF YES, CONTINUE WITH SECTION BELOW</b>	
What type of counseling did they receive? <b>(Check all that apply)</b>	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Group (including peer counseling)
How many sessions were provided before the youth entered BCP Shelter?	Provide #: _____ <b>(estimate is okay)</b>
How many sessions had been planned as part of the youth's treatment or service plan for BCP Prevention?	Provide #: _____ <b>(estimate is okay)</b>

## SERVICE CONNECTIONS - *Indicate all services provided to youth while in BCP Prevention*

<b>Select all services provided either by the organization or elsewhere in the local community and with which the youth has been connected:</b>
<input type="checkbox"/> Community service/service learning <i>(activities that involve youth in helping others or in the community)</i>
<input type="checkbox"/> Criminal justice/legal services <i>(legal services or guidance provided through an attorney or paralegal)</i>
<input type="checkbox"/> Education <i>(i.e. learning disability assessment, tutoring, GED prep, school enrollment, vocational ed, etc.)</i>
<input type="checkbox"/> Employment and/or training services <i>(services to help youth obtain &amp; retain employment, such as assessment, coaching, filling out applications, interviewing, practicing &amp; conducting job searches, referrals, &amp; job maintenance skills)</i>
<input type="checkbox"/> Health/medical care <i>(general health care or surgical services by licensed medical practitioners; may include prenatal testing or other health screenings)</i>
<input type="checkbox"/> Home-based services <i>(any range of services offered at home, usually aimed at keeping a youth from running away or the family stabilized)</i>
<input type="checkbox"/> Life skills training <i>(formal &amp; informal coaching/training in communication skills, health promotion, conflict/anger management, assertiveness, goal setting, budgeting, life planning, nutrition, hygiene, etc.)</i>
<input type="checkbox"/> Parenting education for youth with children <i>(services to build improved parenting skills for youth with children)</i>
<input type="checkbox"/> Post-natal newborn care <i>(services &amp; healthcare provided to the baby after birth, including wellness exams and immunizations)</i>

<input type="checkbox"/> Post-natal care for mother <i>(services &amp; healthcare provided to youth after the birth of a baby, including wellness exams and immunizations)</i>
<input type="checkbox"/> Pre-natal care <i>(services &amp; healthcare provided to expectant youth to ensure a healthy pregnancy, labor, &amp; delivery)</i>
<input type="checkbox"/> STD testing <i>(procedures to test for a range of Sexually Transmitted Infections)</i>
<input type="checkbox"/> Street-based services <i>(services provided to youth on the street, including gateway services, assessment, harm reduction, crisis stabilization, &amp; continuum service linkages)</i>
<input type="checkbox"/> Substance abuse education/prevention <i>(activities related to alcohol and drug abuse prevention, such as education, group activities, peer coaching, refusal skills, etc.)</i>
<input type="checkbox"/> Substance abuse treatment <i>(comprehensive assessment of a youth's current or past involvement with alcohol/ drugs and/or provision of treatment, including screening, aimed at stopping their substance abuse)</i>

<b>DISABILITY ADDENDUM - Complete if there are any updates to youth's disability status</b>		
Do you have a disabling condition? <b>(Documentation is not required; youth's self-report is considered sufficient)</b>	<input type="checkbox"/> Yes <b>*specify below</b> <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>Alcohol abuse without drug abuse:</b> <i>(an impairment caused by alcohol abuse)</i>	<input type="checkbox"/> Yes <b>*ask next question</b> <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<i>If yes for <b>alcohol abuse without drug abuse</b>, is this expected to be of long-continued and indefinite duration and substantially impairs your ability to live independently?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>Drug abuse without alcohol abuse:</b> <i>(an impairment caused by drug abuse)</i>	<input type="checkbox"/> Yes <b>*ask next question</b> <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<i>If yes for <b>drug abuse without alcohol abuse</b>, is this expected to be of long-continued and indefinite duration and substantially impairs your ability to live independently?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>Both alcohol and drug abuse:</b> <i>(an impairment caused by both alcohol and drug abuse)</i>	<input type="checkbox"/> Yes <b>*ask next question</b> <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<i>If yes for <b>both alcohol and drug abuse</b>, is this expected to be of long-continued and indefinite duration and substantially impairs your ability to live independently?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>Chronic health condition:</b> <i>(a diagnosed condition that is more than 3 months in duration and is either not curable or has residual effects that limit daily living and require adaptation/special assistance)</i>	<input type="checkbox"/> Yes <b>*ask next question</b> <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected



<i>If yes for <b>chronic health condition</b>, is this expected to be of long-continued and indefinite duration and substantially impairs your ability to live independently?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>Mental health problem:</b> <i>(a mental health problem may range from situational depression to serious mental illnesses)</i>	<input type="checkbox"/> Yes <b>*ask next question</b> <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<i>If yes for <b>mental health problem</b>, is this expected to be of long-continued and indefinite duration and substantially impairs your ability to live independently?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>Physical disability:</b> <i>(physical impairment)</i>	<input type="checkbox"/> Yes <b>*ask next question</b> <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<i>If yes for <b>physical disability</b>, is this expected to be of long-continued and indefinite duration and substantially impairs your ability to live independently?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>Developmental disability:</b> <i>(severe, chronic disability attributed to a mental and/or physical impairment that occurs before age 22 and limits capacity for independent living and economic self-sufficiency)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Comments/notes:		

**CHILD'S DISABILITY ADDENDUM - Complete for parenting youth households if there has been an update to a child's disability status**

Does your child have any of the following disabilities? <b>(Check all that apply)</b>	<input type="checkbox"/> None <input type="checkbox"/> Chronic health condition <input type="checkbox"/> Mental health problem <input type="checkbox"/> Physical disability <input type="checkbox"/> Developmental disability	<input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Drug abuse <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<i>If yes, which, if any, are expected to be long-continued and substantially impair their ability to live independently?</i> <b>(Check all that apply)</b>	<input type="checkbox"/> None <input type="checkbox"/> Chronic health condition <input type="checkbox"/> Mental health problem <input type="checkbox"/> Physical disability <input type="checkbox"/> Developmental disability	<input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Drug abuse <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected