

VCRHYP RHY PROGRAMS INTAKE ASSESSMENT

CLIENT RECORD		
First name:		
Middle name:		
Last name:		
Suffix: <i>(i.e. Jr., III, etc.)</i>		
Name data quality:	<input type="checkbox"/> Full name recorded <input type="checkbox"/> Partial, street name, or code name recorded	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Do you go by any other names?	If yes, record them here:	
What is your social security number?		
Social security number data quality: (Select "client doesn't know" if youth does not have a SSN)	<input type="checkbox"/> Full SSN recorded <input type="checkbox"/> Approximate or partial SSN recorded	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Are you a U.S. military veteran? (Only ask youth who are 18 or older)	<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
Agency name:		
Agency program:	<input type="checkbox"/> Basic Center – Prevention <input type="checkbox"/> Basic Center – Shelter	<input type="checkbox"/> Transitional Living Program
Name of youth care worker:		
Date of intake/program entry:		
YOUTH DEMOGRAPHICS		
What is your date of birth?		
Date of birth quality:	<input type="checkbox"/> Full DOB recorded <input type="checkbox"/> Approximate or partial DOB recorded	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
What gender do you identify as?	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender female <i>(male to female)</i> <input type="checkbox"/> Transgender male <i>(female to male)</i>	<input type="checkbox"/> Gender non-conforming <i>(not exclusively male or female)</i> <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Do you identify as transgender? (If yes: consult youth about whether they want their HMIS record to reflect that they are transgender: only choose "yes" here if they are okay with that.)	<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
What races do you identify as? (Select up to two; circle whichever the youth identifies first)	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Do you identify as Hispanic or Latino/Latina?	<input type="checkbox"/> No <i>(Non-Hispanic/ Non-Latino/ Non-Latina)</i> <input type="checkbox"/> Yes <i>(Hispanic/ Latino/ Latina)</i>	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
What is your primary language?		

DISABILITIES		
Do you have a disabling condition? (Documentation is not required; youth's self-report is considered sufficient)	<input type="checkbox"/> Yes *specify below <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Alcohol abuse without drug abuse: <i>(an impairment caused by alcohol abuse)</i>	<input type="checkbox"/> Yes *ask next question <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 alcohol abuse without drug abuse, 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
Drug abuse without alcohol abuse: <i>(an impairment caused by drug abuse)</i>	<input type="checkbox"/> Yes *ask next question <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 drug abuse without alcohol abuse, 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
Both alcohol and drug abuse: <i>(an impairment caused by both alcohol and drug abuse)</i>	<input type="checkbox"/> Yes *ask next question <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 both alcohol and drug abuse, 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
Chronic health condition: <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 *ask next question <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 chronic health condition, 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
Mental health problem: <i>(a mental health problem may range from situational depression to serious mental illnesses)</i>	<input type="checkbox"/> Yes *ask next question <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 mental health problem, 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
Physical disability: <i>(physical impairment)</i>	<input type="checkbox"/> Yes *ask next question <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 physical disability, 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
Developmental disability: <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:		

HEALTH INSURANCE		
Do you have health insurance?	<input type="checkbox"/> Yes *specify below <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> (Check all that apply)	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> State children's health ins. <i>(Dr. Dynasaur)</i> <input type="checkbox"/> VA medical services <input type="checkbox"/> Employer-provided <i>(including TRICARE)</i>	<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- Specify: <hr/> <input type="checkbox"/> Data not collected

MONTHLY INCOME – TLP only		
Do you have income from any source?	<input type="checkbox"/> Yes *specify below and provide an estimated monthly amount <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
		Monthly Amount
<input type="checkbox"/> Alimony or other spousal support		\$
<input type="checkbox"/> Child support		\$
<input type="checkbox"/> Earned income (i.e. employment income)		\$
<input type="checkbox"/> General Assistance (GA)		\$
<input type="checkbox"/> Other - Specify: _____		\$
<input type="checkbox"/> Pension or retirement income from a former job		\$
<input type="checkbox"/> Private disability insurance		\$
<input type="checkbox"/> Retirement income from Social Security (includes Social Security Survivor benefits)		\$
<input type="checkbox"/> Social Security Disability Insurance (SSDI)		\$
<input type="checkbox"/> Supplemental Security Income (SSI)		\$
<input type="checkbox"/> TANF (Reach Up)		\$
<input type="checkbox"/> Unemployment insurance		\$
<input type="checkbox"/> VA non-service-connected disability pension		\$
<input type="checkbox"/> VA service-connected disability compensation		\$
<input type="checkbox"/> Worker's compensation		\$
Total monthly income:		\$

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

YOUTH LOCATION

Where did you stay last night?

(Response should be where the youth was the NIGHT PRIOR to program entry)

- 1. Homeless Situation *ask follow-up questions in SECTION 1 below (pg. 5)**
 - Place not meant for habitation (*e.g. vehicle, abandoned building, bus/train/subway station, airport, or anywhere outside*)
 - Emergency shelter, including hotel or motel paid for WITH an emergency shelter voucher or a BCP shelter/host home bed
- 2. Institutional Situation *ask follow-up questions in SECTION 2 (pg. 6)**
 - Foster care home or foster care group home
 - Hospital or other residential non-psychiatric medical facility
 - Jail, prison, or juvenile detention facility
 - Long-term care facility or nursing home
 - Psychiatric hospital or other psychiatric facility
 - Substance abuse treatment facility or detox center
- 3. Temporary/ Permanent Housing *ask follow-up questions in SECTION 3 (pg. 6)**
 - Hotel or motel paid for WITHOUT emergency shelter voucher
 - Non-crisis host home (*this does NOT include BCP or TLP host homes*)
 - Owned by client, NO ongoing housing subsidy
 - Owned by client, WITH ongoing housing subsidy
 - Permanent housing for formerly homeless persons (other than RRH)
 - Rental by client in public housing of a housing authority
 - Rental by client, NO ongoing housing subsidy
 - Rental by client, with RRH or equivalent subsidy
 - Rental by client, with GDP TIP housing subsidy (**Veterans only**)
 - Rental by client, with other ongoing housing subsidy
 - Rental by client, with Housing Choice (Section 8) voucher (*tenant or project based*)
 - Rental by client, with VASH housing subsidy (**Veterans only**)
 - Residential project or halfway house with no homeless criteria
 - Staying or living in a family member's room, apartment, or house
 - Staying or living in a friend's room, apartment, or house
 - Transitional housing for homeless persons (including youth)
- Other *skip to Domestic Violence section on pg. 7**
 - Client doesn't know
 - Client refused
 - Data not collected

SECTION 1. YOUTH IS ENTERING FROM HOMELESS SITUATION

How long have you been staying there?

- | | |
|--|--|
| <input type="checkbox"/> 1 night or less | <input type="checkbox"/> 1 year or longer |
| <input type="checkbox"/> 2-6 nights | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> 1 week or more, but less than 1 month | <input type="checkbox"/> Client refused |
| <input type="checkbox"/> 1 month or more, but less than 90 days | <input type="checkbox"/> Data not collected |
| <input type="checkbox"/> More than 90 days, but less than 1 year | |

When did you start staying on the streets or in emergency shelter? (mm/dd/yyyy)

Ask the youth to think back to the last time they had a place to sleep that wasn't on the streets/ an emergency shelter, then enter the day after that here:

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"/> Client doesn't know |
| <input type="checkbox"/> Two times | <input type="checkbox"/> Client refused |
| <input type="checkbox"/> Three times | <input type="checkbox"/> Data not collected |
| <input type="checkbox"/> Four or more times | |

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"/> Client doesn't know |
| <input type="checkbox"/> 2-12 months - Specify #: _____ | <input type="checkbox"/> Client refused |
| <input type="checkbox"/> More than 12 months | <input type="checkbox"/> Data not collected |

SECTION 2. YOUTH IS ENTERING FROM INSTITUTIONAL SITUATION

How long have you been staying there?	<input type="checkbox"/> 1 night or less *continue below <input type="checkbox"/> 2-6 nights *continue below <input type="checkbox"/> 1 week or more, but less than 1 month *continue below <input type="checkbox"/> 1 month or more, but less than 90 days *continue below	<input type="checkbox"/> More than 90 days, but less than 1 year *Shelter continue below <input type="checkbox"/> 1 year or longer *Shelter continue below <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
IF LENGTH OF STAY WAS LESS THAN 90 DAYS OR YOUTH IS ENTERING BCP SHELTER, CONTINUE BELOW		
On the night before staying there, did you stay on the streets/in emergency shelter?	<input type="checkbox"/> Yes *continue below <input type="checkbox"/> No *BCP Shelter continue below	
IF YES OR YOUTH IS ENTERING BCP SHELTER, CONTINUE WITH SECTION BELOW		
When did you start staying on the streets or in emergency shelter? (mm/dd/yyyy)	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:	
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 - Specify #: _____ <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 3. YOUTH IS ENTERING FROM TEMPORARY/PERMANENT HOUSING

How long have you been staying there?	<input type="checkbox"/> 1 night or less *continue below <input type="checkbox"/> 2-6 nights *continue below <input type="checkbox"/> 1 week or more, but less than 1 month *Shelter continue below <input type="checkbox"/> 1 month or more, but less than 90 days *Shelter continue below	<input type="checkbox"/> More than 90 days, but less than 1 year *Shelter continue below <input type="checkbox"/> 1 year or longer * Shelter continue below <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
IF LENGTH OF STAY WAS LESS THAN 7 NIGHTS OR YOUTH IS ENTERING BCP SHELTER, CONTINUE BELOW		
On the night before staying there, did you stay on the streets/ in emergency shelter?	<input type="checkbox"/> Yes *continue below <input type="checkbox"/> No *BCP Shelter continue below	
IF YES OR YOUTH IS ENTERING BCP SHELTER, CONTINUE WITH SECTION BELOW		
When did you start staying on the streets or in emergency shelter? (mm/dd/yyyy)	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:	
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 - Specify #: _____ <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 *continue below <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
IF YES, CONTINUE WITH SECTION BELOW		
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
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 - Please describe: <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 *ask follow-up question <input type="checkbox"/> No *ask follow-up question	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
If employed, what type of employment is it?	<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
If not employed, why not?	<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
Do you have any current thoughts of harming yourself or others? (“Yes” responses indicate need for further screening for self-harm/ violence towards others)	<input type="checkbox"/> Yes to harming yourself <input type="checkbox"/> Yes to harming others <input type="checkbox"/> No to harming yourself <input type="checkbox"/> No to harming others	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<i>If yes, please explain:</i>		
Have you previously had thoughts of harming yourself or others? (“Yes” responses indicate need for further screening for self-harm/ violence towards others)	<input type="checkbox"/> Yes to harming yourself <input type="checkbox"/> Yes to harming others <input type="checkbox"/> No to harming yourself <input type="checkbox"/> No to harming others	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<i>If so, please explain:</i>		
Have you had thoughts about killing yourself? (“Yes” indicates need for further screening for suicidality)	<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>If so, please explain:</i>		
Are you pregnant?	<input type="checkbox"/> Yes *ask next question <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 *ask next question <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 *ask next question <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 *complete an Addendum for EACH child (pg. 12) <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 *ask next question <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> (Check all that apply)	<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
Have you ever been in DCF foster care in the past?	<input type="checkbox"/> Yes *ask # of years -> <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 how long?</i> <input type="checkbox"/> Less than one year -Specify # of months (1-11): _____ <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 3 to 5 or more years <input type="checkbox"/> Data not collected
Have you or your family ever been involved with DCF in the past other than being in foster care?	<input type="checkbox"/> Yes *ask next question <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 was your past DCF involvement?</i> (Check all that apply)	<input type="checkbox"/> DCF investigation <input type="checkbox"/> Conditional custody order <input type="checkbox"/> Family case with DCF <input type="checkbox"/> 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
Have you ever been under a court order to attend a residential juvenile detention facility? (i.e. Woodside)	<input type="checkbox"/> Yes *ask # of years -> <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 how long?</i> <input type="checkbox"/> Less than one year -Specify # of months (1-11): _____ <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 3 to 5 or more years <input type="checkbox"/> Data not collected
Are you currently involved with the <u>adult</u> criminal justice system? (Drug Court, Parole, Community Service, Probation, etc.)	<input type="checkbox"/> Yes *ask name of officer -> <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected	<i>What is the name of your probation/parole officer/etc.?</i> <i>What is their contact info?</i>
Have you ever been involved with the <u>adult</u> criminal justice system in the past?	<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 subject to or protected by any of the following legal orders? (“Yes” responses indicate need for further discussion about safety and safety planning, as appropriate)	Check all that apply: <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
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Comments/notes:

Are you currently working with any of the following programs? (These may be called something else in your community; use actual program names if possible)	Check all that apply: <input type="checkbox"/> None <input type="checkbox"/> Balanced and Restorative Justice (BARJ) <input type="checkbox"/> Court Diversion <input type="checkbox"/> YHDP Project – Specify: <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
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ARE ANY OF THE FOLLOWING CRITICAL ISSUES FOR YOU? (as identified by youth or staff)		
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 (parents/guardians have insufficient income to support youth’s basic needs)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Incarcerated parent of youth	<input type="checkbox"/> No	<input type="checkbox"/> Yes

HOW WERE YOU REFERRED TO THIS PROGRAM?	
<input type="checkbox"/> Self-referral <input type="checkbox"/> Individual (parent, guardian, relative, friend, foster parent, or other individual) <input type="checkbox"/> Temporary shelter <input type="checkbox"/> Residential project <input type="checkbox"/> Outreach project – Specify # of times youth was approached by outreach prior to entering: ____ <input type="checkbox"/> Hotline <input type="checkbox"/> Child welfare/CPS (DCF)	<input type="checkbox"/> School <input type="checkbox"/> Juvenile justice program <input type="checkbox"/> Law enforcement/police <input type="checkbox"/> Mental hospital <input type="checkbox"/> Other organization – Specify: _____ <input type="checkbox"/> Client doesn’t know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

Youth care worker: did this youth receive brief services or have brief contacts with the agency before coming into the program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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YOUTH CONTACT INFORMATION	
What is the address where you can get mail?	
What is your town of residence?	
What is your email address?	
What is your phone number?	
Is it okay to leave a message at this phone number?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can we say the agency name when we call this phone number?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is the name and contact information for your parents/guardians?	
If you are 18 or older, what is the name and contact information for who we should contact in case of an emergency?	
Are there any other ways to contact you if we lose touch?	

By signing below, I understand that my information will be shared with VCRHYP in order to be entered into the HMIS database:

Youth signature

Date

Youth care worker signature

Date

ADDENDUM FOR PARENTING YOUTH HOUSEHOLDS

Complete this page for EACH child in household

First name:		
Middle name:		
Last name:		
Suffix: <i>(i.e. Jr., III, etc.)</i>		
Name data quality:	<input type="checkbox"/> Full name recorded <input type="checkbox"/> Partial, street name, or code name recorded	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Social security number:		
Social security number data quality: (Select "client doesn't know" if child does not have a Social Security #)	<input type="checkbox"/> Full SSN recorded <input type="checkbox"/> Approximate or partial SSN recorded	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
What is your child's date of birth?		
Date of birth quality:	<input type="checkbox"/> Full DOB recorded <input type="checkbox"/> Approximate or partial DOB recorded	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
What is your child's gender?	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender female <input type="checkbox"/> Transgender male	<input type="checkbox"/> Gender non-conforming <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
What is your child's race? (Select up to two; circle whichever the parent identifies first)	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Is your child Hispanic or Latino/Latina?	<input type="checkbox"/> Yes <i>(Hispanic/Latino/Latina)</i> <input type="checkbox"/> No <i>(Non-Hispanic/ Non-Latino/ Non-Latina)</i>	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

CHILD'S HEALTH INFORMATION

Does your child have any of the following disabilities? (Check all that apply)	<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> (Check all that apply)	<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
Does your child have any of the following types of health insurance? (Check all that apply)	<input type="checkbox"/> None <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> State children's health ins. <i>(Dr. Dynasaur)</i> <input type="checkbox"/> VA medical services <input type="checkbox"/> Employer-provided <i>(including TRICARE)</i>	<input type="checkbox"/> COBRA <input type="checkbox"/> Private pay <input type="checkbox"/> Indian health services <input type="checkbox"/> Other – Specify: <hr style="width: 100%;"/> <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected