

## VCRHYP RHY PROGRAMS PROJECT REENTRY FORM

<b>CLIENT RECORD</b>		
Client ID # from HMIS:		
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 program reentry:	<b>Note: date must be one month or less after youth exited the program in order to use this Reentry Form</b>	

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

<b>SECTION 1. YOUTH IS ENTERING FROM HOMELESS SITUATION</b>		
How long have you been 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

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

<b>SECTION 3. YOUTH IS ENTERING FROM TEMPORARY/PERMANENT HOUSING</b>		
How long have you been staying there?	<input type="checkbox"/> 1 night or less <b>*continue below</b> <input type="checkbox"/> 2-6 nights <b>*continue below</b> <input type="checkbox"/> 1 week or more, but less than 1 month <b>*Shelter continue below</b> <input type="checkbox"/> 1 month or more, but less than 90 days <b>*Shelter continue below</b>	<input type="checkbox"/> More than 90 days, but less than 1 year <b>*Shelter continue below</b> <input type="checkbox"/> 1 year or longer <b>* Shelter continue below</b> <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>IF LENGTH OF STAY WAS LESS THAN 7 NIGHTS OR YOUTH IS ENTERING BCP SHELTER, CONTINUE BELOW</b>		
On the night before staying there, did you stay on the streets/ in emergency shelter?	<input type="checkbox"/> Yes <b>*continue below</b> <input type="checkbox"/> No <b>*BCP Shelter continue below</b>	
<b>IF YES OR YOUTH IS ENTERING BCP SHELTER, CONTINUE WITH SECTION BELOW</b>		
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 <b>wasn't</b> on the streets/ an emergency shelter, then enter the <b>day after</b> 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 (this is the first time) <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

<b>DOMESTIC VIOLENCE</b>		
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

<b>RHY SPECIFIC DATA</b>		
<b>BCP only - Youth care worker:</b> Is youth a runaway?	<input type="checkbox"/> Yes (youth under 18 years of age who absents themselves from home/place of legal residence without the permission of a parent/legal guardian)	<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><i>If employed, what type of employment is it?</i></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><i>If not employed, why not?</i></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
Do you have any current thoughts of harming yourself or others? ( <b>"Yes" responses indicate need for further screening for self-harm/violence towards others</b> )	<input type="checkbox"/> Yes to harming <b>yourself</b> <input type="checkbox"/> Yes to harming <b>others</b> <input type="checkbox"/> No to harming <b>yourself</b> <input type="checkbox"/> No to harming <b>others</b>	<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 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 <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>		
Have any children joined your household since you last exited the program?	<input type="checkbox"/> Yes <b>*complete an Addendum for EACH child (pg. 7)</b> <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>  (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
Are you currently involved with the <u>adult</u> criminal justice system? (Drug Court, Parole, Community Service, Probation, etc.)	<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>What is the name of your probation/parole officer/etc.?</b>  <b>What is their contact info?</b>
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)	<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?  (These may be called something else in your community; use actual program names if possible)	<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?</b> <i>(as identified by youth or staff)</i>		
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>HOW WERE YOU REFERRED TO THIS PROGRAM?</b>	
<input type="checkbox"/> Self-referral <input type="checkbox"/> Individual <i>(parent, guardian, relative, friend, foster parent, or other individual)</i> <input type="checkbox"/> Temporary shelter <input type="checkbox"/> Residential project <input type="checkbox"/> Outreach project – <b>Specify # of times youth was approached by outreach prior to entering:</b> _____ <input type="checkbox"/> Hotline <input type="checkbox"/> Child welfare/CPS <i>(DCF)</i>	<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 – <b>Specify:</b> <hr/> <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>Youth care worker:</b> <i>did this youth receive brief services or have brief contacts with the agency before coming into the program?</i>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	

## ADDENDUM FOR PARENTING YOUTH HOUSEHOLDS

*Complete this page for EACH new 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: <b>(Select "client doesn't know" if child does not have a Social Security #)</b>	<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? <b>(Select up to two; circle whichever the parent identifies first)</b>	<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? <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
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. <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 – <b>Specify:</b> <hr style="width: 100%;"/> <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected