

VCRHYP RHY PROGRAMS PROJECT REENTRY FORM

CLIENT RECORD		
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:	Note: date must be one month or less after youth exited the program in order to use this Reentry Form	

YOUTH LOCATION	
Where did you stay last night? (Response should be where the youth was the NIGHT PRIOR to program entry)	<p>1. Homeless Situation *ask follow-up questions in SECTION 1 below (pg.2)</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>2. Institutional Situation *ask follow-up questions in SECTION 2 (pg. 2)</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>3. Temporary/ Permanent Housing *ask follow-up questions in SECTION 3 (pg. 3)</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 (Veterans only) <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 (Veterans only) <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>Other *skip to Domestic Violence section on pg. 3</p> <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> 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"/> 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)	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 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		
<i>On the night before staying there, did you stay on the streets/in emergency shelter?</i>	<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		
<i>When did you start staying on the streets or in emergency shelter? (mm/dd/yyyy)</i>	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:	
<i>How many times have you been on the streets/ in emergency shelter in the past 3 years (including today)?</i>	<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
<i>How many months were you on the streets/ in emergency shelter in the past 3 years?</i>	<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
<i>If employed, what type of employment is it?</i>	<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
<i>If not employed, why not?</i>	<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 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>		
Have any children joined your household since you last exited the program?	<input type="checkbox"/> Yes *complete an Addendum for EACH child (pg. 7) <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
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	What is the name of your probation/parole officer/etc.? What is their contact info?
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
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

ARE ANY OF THE FOLLOWING CRITICAL ISSUES FOR YOU? <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

HOW WERE YOU REFERRED TO THIS PROGRAM?	
<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 – Specify # of times youth was approached by outreach prior to entering: _____ <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 – Specify: _____ <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Youth care worker: <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: (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