

## VCRHYP RHY PROGRAMS QUARTERLY UPDATE

CLIENT RECORD		
Client ID # from HMIS:		
Name of youth care worker:		
Agency name:		
Date update is completed:		
Agency program:	<input type="checkbox"/> Basic Center – Prevention <input type="checkbox"/> Basic Center – Shelter	<input type="checkbox"/> Transitional Living Program
Is this youth currently on the Coordinated Entry list?	<input type="checkbox"/> Yes <b>*complete the Coordinated Entry Update section on pg. 3</b>	<input type="checkbox"/> No <input type="checkbox"/> Unknown <b>*VCRHYP will review and follow up with you</b>

BROKERED HOUSING - <i>BCP Prevention only</i>	
Did the program provide brokered housing for the youth during the previous quarter? ( <i>Brokered housing is defined as: helping a youth set up and/or maintain housing with a trusted adult they know, other than a guardian, as an alternative to living on their own, couch-surfing, going home, etc.</i> )	<input type="checkbox"/> Yes <b>*answer next question</b> <input type="checkbox"/> No
<i>If yes, how many nights of brokered housing were provided?</i>	

DISABILITIES		
Have there been any updates to your disability status?	<input type="checkbox"/> Yes <b>*complete Disability Addendum on pg. 5</b>	<input type="checkbox"/> No

MONTHLY INCOME – <i>TLP Only</i>		
Do you have income from any source?	<input type="checkbox"/> Yes <b>*specify below and provide an estimated monthly amount</b> <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		\$
<input type="checkbox"/> General Assistance		\$
<input type="checkbox"/> Other - <b>Specify:</b> _____		\$
<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		\$
<input type="checkbox"/> Social Security Disability Insurance ( <i>SSDI</i> )		\$
<input type="checkbox"/> Supplemental Security Income ( <i>SSI</i> )		\$
<input type="checkbox"/> TANF ( <i>Reach Up</i> )		\$
<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		\$
<b>Total monthly income:</b>		<b>\$</b>

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 <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
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- <b>Specify:</b> <hr/> <input type="checkbox"/> Data not collected

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
If yes, which of the following types of health insurance do you have?  (Check all that apply)	<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> <hr/> <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?  (Check all that apply)	<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> <hr/> <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 Health Addendum on pg. 6</b>	<input type="checkbox"/> No

PREGNANCY & PARENTING STATUS		
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
If yes, what is your due date?		
<b>TLP only:</b> Did any children join your household in the previous quarter?	<input type="checkbox"/> Yes <b>*complete Addendum for Parenting Youth Households for EACH child on pg. 7</b>	<input type="checkbox"/> No

<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>SERVICE CONNECTIONS - Indicate all services provided to the youth during last quarter</b>
<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 (activities that involve youth in helping others or in the community)
<input type="checkbox"/> Criminal justice/legal services (legal services or guidance provided through an attorney or paralegal)
<input type="checkbox"/> Education (i.e. learning disability assessment, tutoring, GED prep, school enrollment, vocational ed, etc.)
<input type="checkbox"/> Employment and/or training services (services to help youth obtain & retain employment, such as assessment, coaching, filling out applications, interviewing, practicing & conducting job searches, referrals, & job maintenance skills)
<input type="checkbox"/> Health/medical care (general health care or surgical services by licensed medical practitioners; may include prenatal testing or other health screenings)
<input type="checkbox"/> Home-based services (any range of services offered at home, usually aimed at keeping a youth from running away or the family stabilized)
<input type="checkbox"/> Life skills training (formal & informal coaching/training in communication skills, health promotion, conflict/anger management, assertiveness, goal setting, budgeting, life planning, nutrition, hygiene, etc.)
<input type="checkbox"/> Parenting education for youth with children (services to build improved parenting skills for youth with children)
<input type="checkbox"/> Post-natal newborn care (services & healthcare provided to the baby after birth, including wellness exams and immunizations)
<input type="checkbox"/> Post-natal care for mother (services & healthcare provided to youth after the birth of a baby, including wellness exams and immunizations)
<input type="checkbox"/> Pre-natal care (services & healthcare provided to expectant youth to ensure a healthy pregnancy, labor, & delivery)
<input type="checkbox"/> STD testing (procedures to test for a range of Sexually Transmitted Infections)
<input type="checkbox"/> Street-based services (services provided to youth on the street, including gateway services, assessment, harm reduction, crisis stabilization, & continuum service linkages)
<input type="checkbox"/> Substance abuse education/prevention (activities related to alcohol and drug abuse prevention, such as education, group activities, peer coaching, refusal skills, etc.)
<input type="checkbox"/> Substance abuse treatment (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)

**COORDINATED ENTRY UPDATE – Complete for youth on the CE master list**

<b>Youth care worker:</b> did the youth request to be removed from the CE master list?	<input type="checkbox"/> Yes <b>*skip to CE Exit section</b>	<input type="checkbox"/> No
<b>Youth care worker:</b> is the youth still homeless or at risk of becoming homeless?	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>*skip to CE Exit section</b>	<input type="checkbox"/> Unknown <b>*VCRHYP will follow-up</b>
<b>Youth care worker:</b> has the youth’s housing situation changed since they were assessed/last updated for CE?	<input type="checkbox"/> Yes <b>*complete Section 4 of VCEH CE Housing Assessment &amp; submit to VCRHYP</b>	<input type="checkbox"/> No <input type="checkbox"/> Unknown <b>*VCRHYP will follow-up</b>

**CE EXIT – Complete to have youth exited from Coordinated Entry**

<b>Youth care worker:</b> When did the youth stop meeting the definition of homeless/ at-risk of homelessness OR request to be removed from the CE master list?	<b>Enter full date (mm/dd/yyyy) – an estimate is okay:</b>
<b>Youth care worker:</b> Where was the youth staying on the above date?	<input type="checkbox"/> Emergency shelter, including hotel/motel paid for WITH emergency voucher or a BCP shelter/host home bed <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"/> Hotel or motel paid for WITHOUT emergency shelter voucher <input type="checkbox"/> Jail, prison, or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <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 (other than RRH) for formerly homeless persons <input type="checkbox"/> Place not meant for human habitation <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <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 GPD 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/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 with family, permanent tenure <input type="checkbox"/> Staying or living with family, temporary tenure <input type="checkbox"/> Staying or living with friends, permanent tenure <input type="checkbox"/> Staying or living with friends, temporary tenure <input type="checkbox"/> Substance abuse treatment facility or detox center <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Other - <b>Specify:</b> _____ <input type="checkbox"/> No exit interview completed <input type="checkbox"/> Client is deceased <input type="checkbox"/> Client doesn’t know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

**DISABILITY ADDENDUM - Complete if there are any updates to youth's disability status**

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
<b>Alcohol abuse without drug abuse:</b> (an impairment caused by alcohol abuse)	<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
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?	<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> (an impairment caused by drug abuse)	<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
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?	<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> (an impairment caused by both alcohol and drug abuse)	<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
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?	<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> (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)	<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
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?	<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> (a mental health problem may range from situational depression to serious mental illnesses)	<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
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?	<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:		

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

## 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