

YHDP HMIS Change in Location Form

To be used when a youth is evicted from or vacates a RRH unit, but remains in the program

CLIENT RECORD	
Client ID # from HMIS:	
Name of youth care worker:	
Agency name:	
Date of the youth's last night in the RRH unit:	
Where are staying now that you have left the RRH unit?	<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"/> Place not meant for human habitation (<i>e.g. vehicle, abandoned building, bus/train/subway station, airport, or anywhere outside</i>) <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <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 (<i>family has placed any limitation, such as a specific time limit, that indicates the stay is intended to be temporary</i>) <input type="checkbox"/> Staying or living with friends, permanent tenure <input type="checkbox"/> Staying or living with friends, temporary tenure (<i>friend has placed any limitation, such as a specific time limit, that indicates the stay is intended to be temporary</i>) <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 - Specify: _____ <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

SAFE & APPROPRIATE LOCATION		
Does the youth consider where they are staying after leaving the RRH unit to be safe?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Does the youth care worker consider where the youth is staying after leaving the RRH unit to be safe?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Youth care worker doesn't know
Does the youth have permanent positive adult connections outside of the program?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Youth care worker doesn't know
Does the youth have permanent positive peer connections outside of the program?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Youth care worker doesn't know
Does the youth have permanent positive community connections outside of the program?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Youth care worker doesn't know

HOUSING HISTORY		
How long were you staying in the RRH unit before leaving?	<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 <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
IF LENGTH OF STAY WAS LESS THAN 7 NIGHTS, CONTINUE BELOW		
On the night before staying in the RRH unit, did you stay on the streets or in emergency shelter?	<input type="checkbox"/> Yes *continue below <input type="checkbox"/> No	
IF YES, 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 wasn't on the streets/ an emergency shelter before entering the RRH unit, 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"/> 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

MONTHLY INCOME		
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>i.e. employment income</i>)		\$
<input type="checkbox"/> General Assistance (<i>GA</i>)		\$
<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 (<i>includes Social Security Survivor benefits</i>)		\$
<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		\$
Total monthly income:		\$

NON-CASH BENEFITS		
Do you receive non-cash benefits from any source?	<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 non-cash benefits do you receive?</i> (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: <hr/> <input type="checkbox"/> Data not collected

DISABILITIES		
Have there been any updates to your disability status?	<input type="checkbox"/> Yes *complete Disability Addendum on pg. 7	<input type="checkbox"/> No

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. (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 adult health ins. <input type="checkbox"/> Indian health services <input type="checkbox"/> Other- Specify: <hr/> <input type="checkbox"/> Data not collected

CHILD'S HEALTH INFORMATION – Skip if youth is not parenting		
Does your child 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 does your child have?</i> (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"/> Indian health services <input type="checkbox"/> Other- Specify: <hr/> <input type="checkbox"/> Data not collected
Have there been any updates to your child's disability status?	<input type="checkbox"/> Yes *complete Child Disability Addendum (pg. 8)	<input type="checkbox"/> No

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

ADDITIONAL DATA		
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>includes day labor</i>) <input type="checkbox"/> Date 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 seen a dentist 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 mental health status?	<input type="checkbox"/> Excellent <input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> Fair	<input type="checkbox"/> Poor <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Are you pregnant?	<input type="checkbox"/> Yes *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 <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>		
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 (<i>foster care</i>) <input type="checkbox"/> Conditional custody order <input type="checkbox"/> Open family case with DCF <input type="checkbox"/> On juvenile probation	<input type="checkbox"/> Youthful offender status <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Are you currently involved with the <u>adult</u> criminal justice system? (<i>Drug Court, Parole, Community Service, Probation, etc.</i>)	<input type="checkbox"/> Yes <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 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 (<i>BARJ</i>) <input type="checkbox"/> Court Diversion <input type="checkbox"/> VCRHYP Basic Center Program (<i>BCP</i>) <input type="checkbox"/> VCRHYP Transitional Living Program (<i>TLP</i>)	<input type="checkbox"/> Youth in Transition (<i>YIT</i>) <input type="checkbox"/> Youth Development Program (<i>YDP</i>) <input type="checkbox"/> Prevention & Stabilization Services for Youth/Families (<i>PSSYF</i>) <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

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

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

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
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
HIV/ AIDS: <i>(human immunodeficiency virus/ acquired immunodeficiency syndrome)</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

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

Does your child have any of the following disabilities? (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"/> HIV/ AIDS	<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"/> HIV/ AIDS	<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