

YHDP HMIS Quarterly Update

CLIENT RECORD		
Client ID # from HMIS:		
Name of youth care worker:		
Agency name:		
Date update is completed:		
Agency program:	<input type="checkbox"/> Housing Navigation <input type="checkbox"/> Diversion	<input type="checkbox"/> Rapid Rehousing <input type="checkbox"/> Joint Component
Is this youth currently on the Coordinated Entry list?	<input type="checkbox"/> Yes *complete the Coordinated Entry Update section on pg. 3	<input type="checkbox"/> No <input type="checkbox"/> Unknown *VCRHYP will review and follow up with you

DISABILITIES		
Have there been any updates to your disability status?	<input type="checkbox"/> Yes *complete Disability Addendum on pg. 4	<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. (<i>Dr. Dynasaur</i>) <input type="checkbox"/> VA medical services <input type="checkbox"/> Employer-provided (<i>including TRICARE</i>)	<input type="checkbox"/> COBRA <input type="checkbox"/> Private pay <input type="checkbox"/> State adult health ins. <input type="checkbox"/> Indian health services <input type="checkbox"/> Other- Specify: <hr style="width: 100%;"/> <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. (<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
Have there been any updates to your child's disability status?	<input type="checkbox"/> Yes *complete Child Disability Addendum on pg. 5	<input type="checkbox"/> No

PREGNANCY & PARENTING STATUS		
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>		
Did any children join your household in the previous quarter?	<input type="checkbox"/> Yes *complete Addendum for Parenting Youth Households for EACH child on pg. 6	<input type="checkbox"/> No

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 (GA)		\$
<input type="checkbox"/> Other - Specify: _____		\$
<input type="checkbox"/> Pension or retirement income from a former job		\$
<input type="checkbox"/> Private disability insurance		\$
<input type="checkbox"/> Retirement income from Social Security (<i>includes Social Security Survivor benefits</i>)		\$
<input type="checkbox"/> Social Security Disability Insurance (SSDI)		\$
<input type="checkbox"/> Supplemental Security Income (SSI)		\$
<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 (<i>3SquaresVT/food stamps</i>) <input type="checkbox"/> WIC <input type="checkbox"/> TANF (<i>Reach Up</i>) child care services <input type="checkbox"/> TANF (<i>Reach Up</i>) transportation services	<input type="checkbox"/> Other TANF (<i>Reach Up</i>) services <input type="checkbox"/> Other source- Specify: _____ <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

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

CE EXIT – Complete to have youth exited from Coordinated Entry	
Youth care worker: When did the youth stop meeting the definition of homeless/ at-risk of homelessness OR request to be removed from the CE master list?	Enter full date (mm/dd/yyyy) – an estimate is okay:
Youth care worker: 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 (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/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 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 - Specify: _____ <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
Alcohol abuse without drug abuse: (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 alcohol abuse without drug abuse , 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
Drug abuse without alcohol abuse: (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 drug abuse without alcohol abuse , 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
Both alcohol and drug abuse: (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 both alcohol and drug abuse , 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
Chronic health condition: (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 chronic health condition , 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
Mental health problem: (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

<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 – <i>Complete for parenting youth households if there has been an update to a child's disability status</i>		
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

ADDENDUM FOR PARENTING YOUTH HOUSEHOLDS

Complete this page for EACH child who joined the household in the previous quarter

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
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"/> HIV/AIDS <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<i>If they have a disability, 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"/> HIV/AIDS <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected