

## YHDP HMIS Quarterly Update

<b>CLIENT RECORD</b>		
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
Quarter being reviewed:	<input type="checkbox"/> Quarter 1 (Oct, Nov, Dec) <input type="checkbox"/> Quarter 2 (Jan, Feb, Mar)	<input type="checkbox"/> Quarter 3 (Apr, May, Jun) <input type="checkbox"/> Quarter 4 (Jul, Aug, Sep)

<b>PREGNANCY STATUS</b>		
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>		

<b>DISABILITIES</b>		
Have there been any updates to your disability status?	<input type="checkbox"/> Yes <b>*complete Disability Addendum on pg. 3</b>	<input type="checkbox"/> No

<b>HEALTH INSURANCE</b>		
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
<i>If yes, which of the following types of health insurance do you have?</i>  <b>(Check all that apply)</b>	<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"/> COBRA <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- <b>Specify:</b> _____ <input type="checkbox"/> Data not collected

<b>CHILD'S HEALTH INFORMATION – Skip if youth is not parenting</b>		
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> _____ <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. 4</b>	<input type="checkbox"/> No

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

<b>NON-CASH BENEFITS</b>		
Do you receive non-cash benefits from any source?	<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
<i>If yes, which of the following types of non-cash benefits do you receive?</i>  <b>(Check all that apply)</b>	<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- <b>Specify:</b> _____ <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>DISABILITY ADDENDUM</b> - 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 <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
<b>Alcohol abuse without drug abuse:</b> (an impairment caused by alcohol abuse)	<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>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?</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>Drug abuse without alcohol abuse:</b> (an impairment caused by drug abuse)	<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>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?</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>Both alcohol and drug abuse:</b> (an impairment caused by both alcohol and drug abuse)	<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>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?</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>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 <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>chronic health condition</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>Mental health problem:</b> (a mental health problem may range from situational depression to serious mental illnesses)	<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>mental health problem</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>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>HIV/ AIDS:</b> <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
<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

<b>CHILD'S DISABILITY ADDENDUM</b> - 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?  <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"/> 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> <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"/> 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