

## VCRHYP INTAKE ASSESSMENT

<b>CLIENT RECORD</b>		
First name:		
Middle name:		
Last name:		
Suffix:		
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
Do you go by any other names?	<i><b>If yes, record them here:</b></i>	
What is your social security number?		
Social security number data quality:	<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
Are you a U.S. military veteran? <i>(only ask youth who are 18 or older)</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
Agency name:		
Agency program:	<input type="checkbox"/> Basic Center – Prevention <input type="checkbox"/> Basic Center – Shelter <input type="checkbox"/> State – BCP	<input type="checkbox"/> Transitional Living Program <input type="checkbox"/> State - TLP
Name of youth care worker:		
Date of intake/project entry:		

<b>CLIENT DEMOGRAPHICS</b>		
What is your 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 gender do you identify as?	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender female <i>(male to female)</i> <input type="checkbox"/> Transgender male <i>(female to male)</i>	<input type="checkbox"/> Gender non-conforming <i>(not exclusively male or female)</i> <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<i>Do you identify as transgender?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Declined to answer
What races do you identify as? <i>(select up to two)</i>  <i>Youth care worker: circle whichever the youth identifies first</i>	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Do you identify as Hispanic or Latino/Latina?	<input type="checkbox"/> No <i>(Non-Hispanic/ Non-Latino/ Non-Latina)</i> <input type="checkbox"/> Yes <i>(Hispanic/ Latino/ Latina)</i>	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

What is your primary language?	
Client location:	<input type="checkbox"/> VT-500 Vermont Balance of State CoC <input type="checkbox"/> VT-501 Burlington/Chittenden County CoC

## DISABILITIES

Do you have a disabling condition?	<input type="checkbox"/> Yes <b>*specify below</b> <input type="checkbox"/> No <b>*select "No" for each type below</b>	<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> <i>(an impairment caused by alcohol abuse)</i>	<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>		
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
Is your condition going to be long term?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Drug abuse without alcohol abuse:</b> <i>(an impairment caused by drug abuse)</i>	<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>		
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
Is your condition going to be long term?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Both alcohol and drug abuse:</b> <i>(an impairment caused by both alcohol and drug abuse)</i>	<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>		
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
Is your condition going to be long term?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Chronic health condition:</b> <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 <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>		
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
Is your condition going to be long term?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>Mental health problem:</b> <i>(select "Yes" if problem was a cause of homelessness, a significant issue for the individual, or is of a serious nature)</i>	<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>		
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
Is your condition going to be long term?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Physical disability:</b> <i>(physical impairment)</i>	<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>		
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
Is your condition going to be long term?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<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 <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>		
Is this expected to substantially impair 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
Is your condition going to be long term?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>Comments/notes:</i>		

<b>HEALTH INSURANCE</b>			
Do you have health insurance?	<input type="checkbox"/> Yes <b>*specify below</b> <input type="checkbox"/> No <b>*select "No" for each type below</b>		<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Medicaid:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
Medicare:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
State children's ins. program:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
VA medical services:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
Employer-provided health ins.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
COBRA:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
Private pay health insurance:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
State health ins. for adults:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
Indian health services program:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
Other:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
<i>Medicaid ID number:</i>			

<b>MONTHLY INCOME – TLP and State TLP only</b>				
Do you have income from any source?	<input type="checkbox"/> Yes <b>*specify below</b> <input type="checkbox"/> No <b>*select “No” for each type below</b>			<input type="checkbox"/> Client doesn’t know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Alimony or other spousal support:	<input type="checkbox"/> Yes	Monthly Amount \$	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
Child support:	<input type="checkbox"/> Yes	\$	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
Earned income:	<input type="checkbox"/> Yes	\$	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
General Assistance:	<input type="checkbox"/> Yes	\$	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
Other:	<input type="checkbox"/> Yes	\$	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
Pension or retirement income from a former job:	<input type="checkbox"/> Yes	\$	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
Private disability insurance:	<input type="checkbox"/> Yes	\$	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
Retirement income from SS:	<input type="checkbox"/> Yes	\$	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
SSDI:	<input type="checkbox"/> Yes	\$	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
SSI:	<input type="checkbox"/> Yes	\$	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
TANF (Reach Up):	<input type="checkbox"/> Yes	\$	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
Unemployment insurance:	<input type="checkbox"/> Yes	\$	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
VA non-service-connected disability pension:	<input type="checkbox"/> Yes	\$	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
VA service-connected disability compensation:	<input type="checkbox"/> Yes	\$	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
Worker’s compensation:	<input type="checkbox"/> Yes	\$	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
<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 <b>*select “No” for each type below</b>		<input type="checkbox"/> Client doesn’t know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
SNAP (3SquaresVT/food stamps):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
WIC:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
Reach Up child care services:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
Reach Up transportation services:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
Other Reach Up services:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected
Other source:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Data not collected

<b>CLIENT LOCATION</b>		
<p>Where did you stay last night?</p> <p><i>(response should be where the client was the NIGHT PRIOR to project entry)</i></p>	<p><b>1. Homeless Situation *ask follow-up questions in section 1 below (pg. 5)</b></p> <p><input type="checkbox"/> Place not meant for habitation (e.g. a vehicle, an abandoned building, bus/train/subway station/airport, or anywhere outside)</p> <p><input type="checkbox"/> Emergency shelter, including hotel or motel paid for WITH an emergency shelter voucher</p> <p><b>2. Institutional Situation *ask follow-up questions in section 2 on pg. 6</b></p> <p><input type="checkbox"/> Foster care home or foster care group home</p> <p><input type="checkbox"/> Hospital or other residential non-psychiatric medical facility</p> <p><input type="checkbox"/> Jail, prison, or juvenile detention facility</p> <p><input type="checkbox"/> Long-term care facility or nursing home</p> <p><input type="checkbox"/> Psychiatric hospital or other psychiatric facility</p> <p><input type="checkbox"/> Substance abuse treatment facility or detox center</p> <p><b>3. Transitional and Permanent Housing Situation *ask follow-up questions in section 3 on pg. 6</b></p> <p><input type="checkbox"/> Hotel or motel paid for WITHOUT emergency shelter voucher</p> <p><input type="checkbox"/> Owned by client, NO ongoing housing subsidy</p> <p><input type="checkbox"/> Owned by client, WITH ongoing housing subsidy</p> <p><input type="checkbox"/> Permanent housing for formerly homeless persons (other than RRH)</p> <p><input type="checkbox"/> Rental by client, NO ongoing housing subsidy</p> <p><input type="checkbox"/> Rental by client, with VASH subsidy (<b>Veterans only</b>)</p> <p><input type="checkbox"/> Rental by client, with GPD TIP subsidy (<b>Veterans only</b>)</p> <p><input type="checkbox"/> Rental by client, with other ongoing housing subsidy (including RRH)</p> <p><input type="checkbox"/> Residential project or halfway house with no homeless criteria</p> <p><input type="checkbox"/> Staying or living in a family member's room, apartment, or house</p> <p><input type="checkbox"/> Staying or living in a friend's room, apartment, or house</p> <p><input type="checkbox"/> Transitional housing for homeless persons (including youth)</p> <p><b>Other *skip to Domestic Violence section on pg. 7</b></p> <p><input type="checkbox"/> Client doesn't know</p> <p><input type="checkbox"/> Client refused</p> <p><input type="checkbox"/> Data not collected</p>	
<b>1. IF CLIENT IS ENTERING FROM HOMELESS SITUATION</b>		
<p>How long have you been staying there?</p>	<p><input type="checkbox"/> One night or less</p> <p><input type="checkbox"/> Two to six nights</p> <p><input type="checkbox"/> One week or more, but less than one month</p> <p><input type="checkbox"/> One month or more, but less than 90 days</p> <p><input type="checkbox"/> More than three months, but less than one year</p> <p><input type="checkbox"/> One year or longer</p> <p><input type="checkbox"/> Client doesn't know</p> <p><input type="checkbox"/> Client refused</p>	
<p>Approximate date your homelessness started:</p>	<p>(mm/dd/yyyy)</p>	
<p>How many times have you been on the streets/ in emergency shelter in the past 3 years (including today)?</p>	<p><input type="checkbox"/> One time</p> <p><input type="checkbox"/> Two times</p> <p><input type="checkbox"/> Three times</p> <p><input type="checkbox"/> Four or more times</p>	<p><input type="checkbox"/> Client doesn't know</p> <p><input type="checkbox"/> Client refused</p> <p><input type="checkbox"/> Data not collected</p>
<p>How many months were you on the streets/ in emergency shelter in the past 3 years?</p>	<p><input type="checkbox"/> One month (<i>this is the first time</i>)</p> <p><input type="checkbox"/> 2-12 months: <b>specify #</b>__</p> <p><input type="checkbox"/> More than 12 months</p>	<p><input type="checkbox"/> Client doesn't know</p> <p><input type="checkbox"/> Client refused</p> <p><input type="checkbox"/> Data not collected</p>

**2. IF CLIENT IS ENTERING FROM INSTITUTIONAL SITUATION**

How long have you been staying there?	<input type="checkbox"/> One night or less <b>*continue below</b> <input type="checkbox"/> Two to six nights <b>*continue below</b> <input type="checkbox"/> One week or more, but less than one month <b>*continue below</b> <input type="checkbox"/> One month or more, but less than 90 days <b>*continue below</b> <input type="checkbox"/> More than three months, but less than one year <b>*BCP Shelter continue below</b> <input type="checkbox"/> One year or longer <b>*BCP Shelter continue below</b> <input type="checkbox"/> Client doesn't know <b>*BCP Shelter continue below</b> <input type="checkbox"/> Client refused
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**IF LENGTH OF STAY WAS LESS THAN 90 DAYS OR YOUTH IS ENTERING BCP SHELTER, CONTINUE BELOW**

On the night before entering the institutional situation, did you stay on the streets/ in emergency shelter?	<input type="checkbox"/> Yes <b>*continue below</b>	<input type="checkbox"/> No <b>*BCP Shelter continue below</b>
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**IF YES OR YOUTH IS ENTERING BCP SHELTER, CONTINUE WITH SECTION BELOW**

Approximate date your homelessness started:	(mm/dd/yyyy)	
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: <b>specify #</b> __ <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

**3. IF CLIENT IS ENTERING FROM TRANSITIONAL/PERMANENT SITUATION**

How long have you been staying there?	<input type="checkbox"/> One night or less <b>*continue below</b> <input type="checkbox"/> Two to six nights <b>*continue below</b> <input type="checkbox"/> One week or more, but less than one month <b>*BCP Shelter continue below</b> <input type="checkbox"/> One month or more, but less than 90 days <b>*BCP Shelter continue below</b> <input type="checkbox"/> More than three months, but less than one year <b>*BCP Shelter continue below</b> <input type="checkbox"/> One year or longer <b>*BCP Shelter continue below</b> <input type="checkbox"/> Client doesn't know <b>*BCP Shelter continue below</b> <input type="checkbox"/> Client refused
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**IF LENGTH OF STAY WAS LESS THAN 7 NIGHTS OR YOUTH IS ENTERING BCP SHELTER, CONTINUE BELOW**

On the night before entering the transitional/permanent situation, did you stay on the streets/ in emergency shelter?	<input type="checkbox"/> Yes <b>*continue below</b>	<input type="checkbox"/> No <b>*BCP Shelter continue below</b>
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**IF YES OR YOUTH IS ENTERING BCP SHELTER, CONTINUE WITH SECTION BELOW**

Approximate date your homelessness started:	(mm/dd/yyyy)	
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: <b>specify #</b> __ <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

<b>DOMESTIC VIOLENCE</b>		
Has a partner 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"/> Three to six months ago <input type="checkbox"/> Six months to one year ago	<input type="checkbox"/> One 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 a partner?	<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>RHY SPECIFIC DATA</b>		
<b>Youth care worker:</b> Is youth eligible for federal BCP services?	<b>(Yes must be checked if youth is served in BCP Prevention or BCP Shelter)</b>	
	<input type="checkbox"/> Yes <b>*answer follow-up question</b> <input type="checkbox"/> No <b>*answer follow-up question</b>	
<b>Youth care worker:</b> If eligible for federal BCP services, 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"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>Youth care worker:</b> If not eligible, why not? <i>(If any reason is checked here, youth must be served in TLP or State BCP/TLP)</i>	<input type="checkbox"/> Out of age range <input type="checkbox"/> Ward of the state <input type="checkbox"/> Ward of the criminal justice system ( <i>currently under a court order to attend a residential juvenile facility</i> ) <input type="checkbox"/> Other	
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"/> 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 <b>*ask follow-up question</b> <input type="checkbox"/> No <b>*ask follow-up question</b>	<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>(including day labor)</i> <input type="checkbox"/> Data 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
<i>Have you had an annual check-up with a doctor within the last year?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Declined to answer
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
<i>Have you been to the dentist in the last year?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Declined to answer
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
<i>Do you have any current thoughts of harming yourself or others?</i>	<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
<i>If so, please explain:</i>		
<i>Have you previously had thoughts of harming yourself or others?</i>	<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
<i>If so, please explain:</i>		
<i>Have you had thoughts about killing yourself?</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If so, please explain:</i>		
Are you pregnant?	<input type="checkbox"/> Yes <b>*ask next question</b> <input type="checkbox"/> No	<input type="checkbox"/> Client's doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
If yes, what is your due date?		
<i>Is your partner pregnant?</i>	<input type="checkbox"/> Yes <b>*ask next question</b> <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Declined to answer
<i>If yes, what is their due date?</i>		
<i>Do you have any children?</i>	<input type="checkbox"/> Yes <b>*ask next question</b> <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Declined to answer



<i>If yes, do you have custody of your children?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Declined to answer
<i>Are you currently involved with DCF?</i>	<input type="checkbox"/> Yes <b>*ask next question</b> <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Declined to answer
<i>What is your current DCF involvement?</i> <b>(Check all that apply)</b>	<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 <b>*ask next question</b> <input type="checkbox"/> Youthful offender status <b>*ask next question</b>	<input type="checkbox"/> Unknown <b>*if possible, contact DCF district office to determine &amp; provide updated information to VCRHYP</b>
<i>Are you currently involved with any of the following programs?</i> <b>(Check all that apply)</b>	<input type="checkbox"/> Community Justice Center <input type="checkbox"/> Court Diversion Program <input type="checkbox"/> Alternative Restorative Justice Program	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Declined to answer
<i>Have you ever been in DCF foster care in the past?</i>	<input type="checkbox"/> Yes <b>*ask # of years -&gt;</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, for how long?</b> <input type="checkbox"/> Less than one year <b># of months (1-11):</b> ____ <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 3 to 5 or more years <input type="checkbox"/> Data not collected
<i>Have you or your family ever been involved with DCF in the past other than being in foster care?</i>	<input type="checkbox"/> Yes <b>*ask next question</b> <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Declined to answer
<i>What was your past DCF involvement?</i> <b>(Check all that apply)</b>	<input type="checkbox"/> DCF investigation <input type="checkbox"/> Conditional custody order <input type="checkbox"/> Family case with DCF <input type="checkbox"/> Juvenile probation <b>*ask next two questions</b> <input type="checkbox"/> Youthful offender status <b>*ask next two questions</b>	<input type="checkbox"/> Unknown <b>*if possible, contact DCF district office to determine &amp; provide updated information to VCRHYP</b>
<i>How long were you on juvenile probation or youthful offender status?</i>	<input type="checkbox"/> Less than one year <b># of months (1-11):</b> ____ <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 3 to 5 or more years	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<i>Have you ever been involved with any of the following programs in the past?</i> <b>(Check all that apply)</b>	<input type="checkbox"/> Community Justice Center <input type="checkbox"/> Court Diversion Program <input type="checkbox"/> Alternative Restorative Justice Program	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Declined to answer
<i>Are you currently involved with the <u>adult</u> criminal justice system?</i> <i>(Drug Court, Parole, Community Service, Probation, etc.)</i>	<input type="checkbox"/> Yes <b>*ask name of officer -&gt;</b> <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Declined to answer	<b>What is the name of your probation/parole/etc. officer?</b>  <b>What is their contact info?</b>

<i>Have you ever been involved with the <u>adult</u> criminal justice system in the past?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Declined to answer
<i>Are you subject to or protected by any of the following?</i>		
<i>Relief from abuse order?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Declined to answer
<i>Stalking or sexual assault protection order?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Declined to answer
<i>No contact order?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Declined to answer
<i>Other legal orders?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Declined to answer
<i>Comments/notes:</i>		

<b>ARE ANY OF THE FOLLOWING CRITICAL ISSUES FOR YOU?</b> <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

<b>HOW WERE YOU REFERRED TO THIS PROGRAM?</b>		
<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 <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 <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected	
<b>Youth care worker:</b> <i>did this client receive brief services or have brief contacts with the agency before coming into the program?</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>CLIENT CONTACT INFORMATION</b>		
<i>What is the address where you can get mail?</i>		
<i>What is your town of residence?</i>		
<i>What is your email address?</i>		
<i>What is your phone number?</i>		
<i>Is it okay to leave a message at this number?</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>Can we say the agency name when we call this phone number?</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>What is the name and contact information for your parents/guardians?</i>		
<i>If you are 18 or over, what is the name and contact information for who we should contact in case of an emergency?</i>		
<i>Are there any other ways to contact you if we lose touch?</i>		

By signing below, I understand that my information will be shared with VCRHYP in order to be entered into the HMIS database:

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Youth signature Date

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Youth care worker signature Date