

Assessment: Entry/Intake
 Funder(s): HHS: RHY
 Project(s): Basic Center Program Prevention
 Applies To: Child of Parenting Youth



Step 1: Client Demographics

All fields with an * are required

First & Last Name:* _____		
Middle Name: _____		Alias: _____
Name Data Quality:*		
<input type="checkbox"/> Full Name Reported	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Data Not Collected
<input type="checkbox"/> Partial, Street, or Code Name Reported	<input type="checkbox"/> Client Prefers Not to Answer	
Social Security Number:* ____ - ____ - ____		Birth Date:* ____/____/____
<input type="checkbox"/> Full SSN Reported	<input type="checkbox"/> Full DOB Reported	
<input type="checkbox"/> Approximate or Partial SSN Reported	<input type="checkbox"/> Approximate or Partial DOB Reported	
<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Doesn't Know	
<input type="checkbox"/> Client Prefers Not to Answer	<input type="checkbox"/> Client Prefers Not to Answer	
<input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Data Not Collected	
Race and Ethnicity:*		
<input type="checkbox"/> American Indian, Alaska Native, or Indigenous	<input type="checkbox"/> Native Hawaiian or Pacific Islander	Additional Race and Ethnicity Detail:
<input type="checkbox"/> Asian or Asian American	<input type="checkbox"/> White	
<input type="checkbox"/> Black, African American, or African	<input type="checkbox"/> Client doesn't know	
<input type="checkbox"/> Hispanic/Latina/o	<input type="checkbox"/> Client prefers not to answer	
<input type="checkbox"/> Middle Eastern or North African	<input type="checkbox"/> Data not collected	
Sex:*		
<input type="checkbox"/> Female	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Data not collected
<input type="checkbox"/> Male	<input type="checkbox"/> Client prefers not to answer	
Gender:		
<input type="checkbox"/> Woman (Girl, if child)	<input type="checkbox"/> Questioning	If "Different Identity", Please Specify:
<input type="checkbox"/> Man (Boy, if child)	<input type="checkbox"/> Different Identity	
<input type="checkbox"/> Culturally Specific Identity (e.g., Two-Spirit)	<input type="checkbox"/> Client doesn't know	
<input type="checkbox"/> Transgender	<input type="checkbox"/> Client prefers not to answer	
<input type="checkbox"/> Non-Binary	<input type="checkbox"/> Data not collected	
Relationship to Head of Household:*		
<input type="checkbox"/> Head of Household's Child		

Step 2: Project Enrollment

Project Start Date: * ____/____/____	Case Manager: _____
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Step 3: Entry Assessments

Disabling Condition:*		
<input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Data not collected
<input type="checkbox"/> No	<input type="checkbox"/> Client prefers not to answer	
Covered By Health Insurance*		
<input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Data not collected
<input type="checkbox"/> No	<input type="checkbox"/> Client prefers not to answer	
If "Yes, Covered by Health Insurance" – Specify:*		
<input type="checkbox"/> MEDICAID	<input type="checkbox"/> Health Insurance Obtained Through COBRA	
<input type="checkbox"/> MEDICARE	<input type="checkbox"/> Private Pay Health Insurance	
<input type="checkbox"/> State Children's Health Insurance (S-CHIP)	<input type="checkbox"/> State Health Insurance for Adults	
<input type="checkbox"/> Veteran's Health Administration (VHA)	<input type="checkbox"/> Indian Health Services Program	
<input type="checkbox"/> Employer Provided Health Insurance	<input type="checkbox"/> Other (specify): _____	

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BCP Status

To determine the number of homeless persons eligible for FYSB in RHY BCP-funded emergency shelter projects.

Youth Eligible for RHY Services* ☐ Yes ☐ No Date Status Determined* MM / DD / YYYY

If No, for "Youth Eligible for RHY Services"

Reason why services are not funded by BCP grant*

- ☐ Out of age range ☐ Ward of the Criminal Justice System – Immediate Reunification
☐ Ward of the State – Immediate Reunification ☐ Other

If Yes, for "Youth Eligible for RHY Services"

Runaway Youth*

- ☐ Yes ☐ Client doesn't know ☐ Data not collected
☐ No ☐ Client prefers not to answer

Barriers (Disabling Conditions)

Physical Disability*

- ☐ Yes ☐ Client doesn't know ☐ Data not collected
☐ No ☐ Client prefers not to answer

If "Yes, is it Expected to be of Long-Continued & Indefinite Duration and Substantially Impair Ability to Live Independently"

- ☐ Yes ☐ Client doesn't know ☐ Data not collected
☐ No ☐ Client prefers not to answer

Developmental Disability*

- ☐ Yes ☐ Client doesn't know ☐ Data not collected
☐ No ☐ Client prefers not to answer

Chronic Health Condition*

- ☐ Yes ☐ Client doesn't know ☐ Data not collected
☐ No ☐ Client prefers not to answer

If "Yes, is it Expected to be of Long-Continued & Indefinite Duration and Substantially Impair Ability to Live Independently"

- ☐ Yes ☐ Client doesn't know ☐ Data not collected
☐ No ☐ Client prefers not to answer

Mental Health Disorder*

- ☐ Yes ☐ Client doesn't know ☐ Data not collected
☐ No ☐ Client prefers not to answer

If "Yes, is it Expected to be of Long-Continued & Indefinite Duration and Substantially Impair Ability to Live Independently"

- ☐ Yes ☐ Client doesn't know ☐ Data not collected
☐ No ☐ Client prefers not to answer

Alcohol Use Disorder*

- ☐ Yes ☐ Client doesn't know ☐ Data not collected
☐ No ☐ Client prefers not to answer

If "Yes, is it Expected to be of Long-Continued & Indefinite Duration and Substantially Impair Ability to Live Independently"

- ☐ Yes ☐ Client doesn't know ☐ Data not collected
☐ No ☐ Client prefers not to answer

Drug Use Disorder*

- ☐ Yes ☐ Client doesn't know ☐ Data not collected
☐ No ☐ Client prefers not to answer

If "Yes, is it Expected to be of Long-Continued & Indefinite Duration and Substantially Impair Ability to Live Independently"

- ☐ Yes ☐ Client doesn't know ☐ Data not collected
☐ No ☐ Client prefers not to answer