

Assessment: Entry/Intake
Funder(s): HHS: RHY
Project(s): Basic Center Program Prevention
Applies To: Head of Household (Primary) & Adults (18+) - Includes Unaccompanied Youth



Step 1: Client Demographics

All fields with an * are required

First & Last Name:*

Middle Name:

Alias:

Name Data Quality:*

☐ Full Name Reported

☐ Client Doesn't Know

☐ Data Not Collected

☐ Partial, Street, or Code Name Reported

☐ Client Prefers Not to Answer

Social Security Number:*

☐ Full SSN Reported

☐ Approximate or Partial SSN Reported

☐ Client Doesn't Know

☐ Client Prefers Not to Answer

☐ Data Not Collected

Birth Date:*

MM / DD / YYYY

☐ Full DOB Reported

☐ Approximate or Partial SSN Reported

☐ Client Doesn't Know

☐ Client Prefers Not to Answer

☐ Data Not Collected

Race and Ethnicity:*

☐ American Indian, Alaska Native, or Indigenous

☐ Native Hawaiian or Pacific Islander

Additional Race and Ethnicity Detail:

☐ Asian or Asian American

☐ White

☐ Black, African American, or African

☐ Client doesn't know

☐ Hispanic/Latina/o

☐ Client prefers not to answer

☐ Middle Eastern or North African

☐ Data not collected

Sex:*

☐ Female

☐ Client doesn't know

☐ Data not collected

☐ Male

☐ Client prefers not to answer

Gender:

☐ Woman (Girl, if child)

☐ Questioning

If "Different Identity", Please Specify:

☐ Man (Boy, if child)

☐ Different Identity

☐ Culturally Specific Identity (e.g., Two-Spirit)

☐ Client doesn't know

☐ Transgender

☐ Client prefers not to answer

☐ Non-Binary

☐ Data not collected

Pregnancy Status:*

☐ Yes

☐ No

☐ Client prefers not to answer

If Yes, Due Date: MM / DD / YYYY

☐ Client doesn't know

☐ Data not collected

Veteran Status:*

☐ Yes

☐ Client doesn't know

☐ Data not collected

☐ No

☐ Client prefers not to answer

Contact Information

Address:

City/State/Zip:

Email:

Phone:

Relationship to Head of Household:*

☐ Self (Head of Household)

☐ Head of Household's Spouse or Partner

☐ Other: Non-Relation Member

☐ Head of Household's Child

☐ Head of Household's Other Relation Member

Step 2: Project Enrollment

Project Start Date:*

MM / DD / YYYY

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"/> No	<input type="checkbox"/> Data not collected
<input type="checkbox"/> Client prefers not to answer	
Prior Living Situation*	
<i>Identify where the client slept the night before enrollment - <u>ONLY SELECT ONE</u></i>	
Homeless Situations	
<input type="checkbox"/> Place not meant for habitation (e.g., vehicle, abandoned building, bus/train/subway/station/airport, or anywhere outside) <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher <input type="checkbox"/> Safe Haven	
Institutional Situations	Temporary Housing Situations
<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"/> Jail, prison, or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center	<input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Staying or living in a friend's room, apartment, or house <input type="checkbox"/> Staying or living in a family member's room, apartment, or house
Permanent Housing situation	Other
<input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with ongoing housing subsidy <input type="checkbox"/> Rental by client, no ongoing housing subsidy	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
<i>If "Yes, Rental By Client, with Ongoing Housing Subsidy" – Specify:*</i>	
<input type="checkbox"/> GPD TIP housing subsidy <input type="checkbox"/> VASH housing subsidy <input type="checkbox"/> RRH or equivalent subsidy <input type="checkbox"/> HCV voucher (tenant or project based) (not dedicated) <input type="checkbox"/> Public housing unit <input type="checkbox"/> Other permanent housing dedicated for formerly homeless persons	<input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Housing Stability Voucher <input type="checkbox"/> Family Unification Program Voucher (FUP) <input type="checkbox"/> Foster Youth to Independence Initiative (FYI) <input type="checkbox"/> Permanent Supportive Housing
Length of stay in prior living situation:*	
<input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> One month or more, but less than 90 days	<input type="checkbox"/> 90 days or more, but less than one year <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected
<u>FOR INSTITUTIONAL SITUATIONS</u>	<u>FOR TEMPORARY, PERMANENT, & OTHER SITUATIONS</u>
Did you stay less than 90 days: * <input type="checkbox"/> Yes <input type="checkbox"/> No	Did you stay less than 7 nights: * <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If "Yes, Stayed in a Temporary, Permanent or Other Situation for less than 7 nights <u>OR</u> Stayed in an Institutional Situation for less than 90 days</i>	
On the night before did you stay on the streets, ES, or SH:* <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>If "Yes, On the night before did you stay on the streets, ES, or SH" or if Prior Living Situation was a "Homeless Situation"</i>	
Approximate date this episode of homelessness started:* <u>MM / DD / YYYY</u>	
Number of times the client has been on the streets, ES or Safe Haven in the last 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 prefers not to answer <input type="checkbox"/> Data not collected <input type="checkbox"/> Client doesn't know	

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Total number of months homeless on the streets, in ES, or SH in the past three years:*

- | | |
|--|---|
| <input type="checkbox"/> One month (this time is the first month) | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> 2-12 months (specify number of months): _____ | <input type="checkbox"/> Client prefers not to answer |
| <input type="checkbox"/> More than 12 months | <input type="checkbox"/> Data not collected |

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): _____ |

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*** ____/____/____

If No, for "Youth Eligible for RHY Services"

Reason why services are not funded by BCP grant*

- | | |
|--|--|
| <input type="checkbox"/> Out of age range | <input type="checkbox"/> Ward of the Criminal Justice System – Immediate Reunification |
| <input type="checkbox"/> Ward of the State – Immediate Reunification | <input type="checkbox"/> Other |

If Yes, for "Youth Eligible for RHY Services"

Runaway Youth*

- | | | |
|------------------------------|---|---|
| <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 | |

Barriers (Disabling Conditions)

Physical Disability*

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

- | | | |
|------------------------------|---|---|
| <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 | |

Developmental Disability*

- | | | |
|------------------------------|---|---|
| <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 | |

Chronic Health 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 | |

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

- | | | |
|------------------------------|---|---|
| <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 | |

Mental Health Disorder*

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

- | | | |
|------------------------------|---|---|
| <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 | |

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Alcohol Use Disorder*

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

- | | | |
|------------------------------|---|---|
| <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 | |

Drug Use Disorder*

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

- | | | |
|------------------------------|---|---|
| <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 | |

Income from Any Source

- | | | |
|------------------------------|---|---|
| <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, Income from any Source – Specify Type & Monthly Amount:**

- | | |
|---|------------------|
| <input type="checkbox"/> Earned Income | Amount: \$ _____ |
| <input type="checkbox"/> Unemployment Insurance | Amount: \$ _____ |
| <input type="checkbox"/> Supplemental Security Income (SSI) | Amount: \$ _____ |
| <input type="checkbox"/> Social Security Disability Insurance (SSDI) | Amount: \$ _____ |
| <input type="checkbox"/> VA Service-Connected Disability Compensation | Amount: \$ _____ |
| <input type="checkbox"/> VA Non-Service-Connected Disability Pension | Amount: \$ _____ |
| <input type="checkbox"/> Private disability insurance | Amount: \$ _____ |
| <input type="checkbox"/> Worker's Compensation | Amount: \$ _____ |
| <input type="checkbox"/> Temporary Assistance for Needy Families (TANF) | Amount: \$ _____ |
| <input type="checkbox"/> General Assistance (GA) | Amount: \$ _____ |
| <input type="checkbox"/> Retirement income from Social Security | Amount: \$ _____ |
| <input type="checkbox"/> Pension or retirement income from a former job | Amount: \$ _____ |
| <input type="checkbox"/> Child support | Amount: \$ _____ |
| <input type="checkbox"/> Alimony and other spousal support | Amount: \$ _____ |
| <input type="checkbox"/> Other income source (specify): _____ | Amount: \$ _____ |

Non-Cash Benefits from Any Source*

- | | | |
|------------------------------|---|---|
| <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, Non-Cash from Any Source" – Specify Type & Monthly Amount:**

- | | |
|---|------------------|
| <input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) (Previously known as Food Stamps) | Amount: \$ _____ |
| <input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) | Amount: \$ _____ |
| <input type="checkbox"/> TANF Child Care services | Amount: \$ _____ |
| <input type="checkbox"/> TANF transportation services | Amount: \$ _____ |
| <input type="checkbox"/> Other TANF-funded services | Amount: \$ _____ |
| <input type="checkbox"/> Other source (specify): _____ | Amount: \$ _____ |

Employment Assessment

Employed:*

- | | | | | |
|------------------------------|-----------------------------|--|---|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Client prefers not to answer | <input type="checkbox"/> Data not collected |
|------------------------------|-----------------------------|--|---|---|

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*If Yes, "Employed":**

Type of Employment:*

☐ Full-Time
 ☐ Part-Time
 ☐ Seasonal/sporadic (includes day labor)

*If No, "Why Not Employed":**

Why Not Employed:*

☐ Looking for work
 ☐ Unable to work
 ☐ Not looking for work

Education Assessment

Last Grade Completed:*

<input type="checkbox"/> Less than Grade 5	<input type="checkbox"/> School program does not have grade levels	<input type="checkbox"/> Graduate degree
<input type="checkbox"/> Grades 5-6	<input type="checkbox"/> GED	<input type="checkbox"/> Vocational Certification
<input type="checkbox"/> Grades 7-8	<input type="checkbox"/> Some college	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Grades 9-11	<input type="checkbox"/> Associate's degree	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Grade 12/High school diploma	<input type="checkbox"/> Bachelor's degree	<input type="checkbox"/> Data Not Collected

School Status:*

<input type="checkbox"/> Attending school regularly	<input type="checkbox"/> Obtained GED	<input type="checkbox"/> Expelled	<input type="checkbox"/> Data Not Collected
<input type="checkbox"/> Attending school irregularly	<input type="checkbox"/> Dropped Out	<input type="checkbox"/> Client doesn't know	
<input type="checkbox"/> Graduated from high school	<input type="checkbox"/> Suspended	<input type="checkbox"/> Client prefers not to answer	

Health Assessment

General Health Status:*

<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Poor	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Very Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Data not collected

Dental Health Status:*

<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Poor	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Very Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Data not collected

Mental Health Status:*

<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Poor	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Very Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Data not collected

RHY Assessment

Sexual Orientation:

<input type="checkbox"/> Heterosexual	<input type="checkbox"/> Questioning/Unsure	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Gay	<input type="checkbox"/> Other - <i>If "Other", please specify:*</i>	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Lesbian		<input type="checkbox"/> Data Not Collected
<input type="checkbox"/> Bisexual		

Referral Source:*

<input type="checkbox"/> Self-Referral	<input type="checkbox"/> Child Welfare/CPS	<input type="checkbox"/> Other Organization
<input type="checkbox"/> Outreach Project	<input type="checkbox"/> Juvenile Justice	<input type="checkbox"/> Vocational Certification
<input type="checkbox"/> Temporary Shelter	<input type="checkbox"/> Law Enforcement/Police	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Residential Project	<input type="checkbox"/> Mental Hospital	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Hotline	<input type="checkbox"/> School	<input type="checkbox"/> Data Not Collected
<input type="checkbox"/> Individual: Parent/Guardian/Relative/Friend/Foster Parent/Other Individual		

If Outreach Project is selected for "Referral Source"

Number of times approached by outreach prior to entering the project:* _____

Critical Family Issue:*

Status:*

Unemployment - Family member	<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	
Mental Health Disorder - Family member	<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	

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Physical Disability - Family member	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Data Not Collected
Alcohol or Substance Use Disorder – Family member	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Data Not Collected
Insufficient Income to support youth - Family member	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Data Not Collected
Incarcerated Parent of Youth	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Data Not Collected

Formerly Ward Of				
Formerly a Ward of Child Welfare or Foster Care Agency?*				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Data Not Collected
<i>If Yes, "Formerly a Ward of Child Welfare or Foster Care Agency"</i>				
Number of Years:*				
<input type="checkbox"/> Less than one year <i>Number of Months:*</i> _____ (1 - 11)		<input type="checkbox"/> 1 - 2 years	<input type="checkbox"/> 3 - 5 or more years	
Formerly a Ward of Juvenile Justice System?:*				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer	<input type="checkbox"/> Data Not Collected
<i>If Yes, "Formerly a Ward of Juvenile Justice System"</i>				
Number of Years:*				
<input type="checkbox"/> Less than one year <i>Number of Months:*</i> _____ (1 - 11)		<input type="checkbox"/> 1 - 2 years	<input type="checkbox"/> 3 - 5 or more years	