

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



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	
Pregnancy Status:*		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client prefers not to answer
If Yes, Due Date: ____/____/____	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Data not collected
Veteran Status:*(18 and Older)		
<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	
Contact Information		
Address: _____		City/State/Zip: _____
Email: _____		Phone: _____
Relationship to Head of Household:*		
<input type="checkbox"/> Self (Head of Household)	<input type="checkbox"/> Head of Household's Spouse or Partner	<input type="checkbox"/> Other: Non-Relation Member
<input type="checkbox"/> Head of Household's Child	<input type="checkbox"/> Head of Household's Other Relation Member	

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"/> No	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Data not collected	
Prior Living Situation*	
<i>Identify where the client slept the night before enrollment - ONLY SELECT ONE</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 Situations	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
If "Yes, Rental by Client, with Ongoing Housing Subsidy" – Specify:*	
<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
Approximate date this episode of homelessness started:*	
_____ / _____ / _____	
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 doesn't know
<input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	
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"/> 2-12 months (specify number of months): _____ <input type="checkbox"/> More than 12 months	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected

Covered By Health Insurance*

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

*If "Yes, Covered by Health Insurance" – Specify:**

- MEDICAID Health Insurance Obtained Through COBRA
 MEDICARE Private Pay Health Insurance
 State Children's Health Insurance (S-CHIP) State Health Insurance for Adults
 Veteran's Health Administration (VHA) Indian Health Services Program
 Employer Provided Health Insurance 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*

- 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

Income from Any Source

- Yes Client doesn't know Data not collected
 No 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 (<i>specify</i>): _____ | Amount: \$ _____ |

Non-Cash Benefits from Any Source*

- Yes Client doesn't know Data not collected
 No 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 (<i>specify</i>): _____ | Amount: \$ _____ |

Employment Assessment

Employed:*

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

*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

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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 | |
| Physical Disability - 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 | |
| Alcohol or Substance Use 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 | |
| Insufficient Income to support youth - 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 | |
| Incarcerated Parent of 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 | |

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Formerly Ward Of

Formerly a Ward of Child Welfare or Foster Care Agency?*

Yes No Client doesn't know Client prefers not to answer Data Not Collected

If Yes, "Formerly a Ward of Child Welfare or Foster Care Agency"

Number of Years:*

Less than one year
*Number of Months:** _____ (1 - 11) 1 - 2 years 3 - 5 or more years

Formerly a Ward of Juvenile Justice System?*

Yes No Client doesn't know Client prefers not to answer Data Not Collected

If Yes, "Formerly a Ward of Juvenile Justice System"

Number of Years:*

Less than one year
*Number of Months:** _____ (1 - 11) 1 - 2 years 3 - 5 or more years