

HMIS Data Collection for RHY TLP Projects – ENTRY

FOR TEXT FIELDS, USE BLOCK LETTERS. OTHERWISE, MARK APPROPRIATE BOXES WITH AN “X”

The form is broken into two sections for *All Clients*, and *Head of Household and Other Adults in the Household* in order to eliminate duplication of data gathering when characteristics apply to certain members of households.

DATA FOR ALL CLIENTS

Respond to these questions for all household members—each adult and child. A separate form should be included for each household member.

DATA FOR HEAD OF HOUSEHOLD AND OTHER ADULTS

Respond to these questions for the head of household and each additional adult in the household. If the household is composed of an unaccompanied child, that child is the head of household. If the household is composed of two or more minors, data must be collected about the minor that has been designated as the head of household. A separate form should be included for each adult member of the household.

3.10 PROJECT ENTRY DATE (e.g., 09/06/2016) (ALL CLIENTS)

The Project Entry Date will serve as the information date for all data elements collected on this form; all data must be accurate as of this date, regardless of the date collected.

Record the month, day, and year of project entry. The project entry date indicates a client is now being assisted by the project.

- For residential projects, with the exception of Permanent Housing-Rapid Re-Housing (PH-RRH) projects, this should be the first date of occupancy in the project.
- For PH-RRH projects and non-residential projects this should be the date on which the client began receiving services from the project or would otherwise be considered by the project funder to be a project participant for reporting purposes.
- For Street Outreach projects this should be the date of first contact with the client.

		/			/				
Month		Day				Year			

3.1 NAME (first, middle, last name, suffix (e.g., Jr, Sr, III)) (ALL CLIENTS)

To avoid duplicate record creation, the full first name should be used (e.g., James vs. Jim) and the last name should be recorded as the individual has it recorded on their official legal documents (driver's license, social security card, etc.)

First name																			
Middle name																			
Last name																			
Suffix																			

NAME DATA QUALITY (ALL CLIENTS)

Full name reported

Client doesn't know

Partial, street name, or code name reported

Client refused

3.2 SOCIAL SECURITY NUMBER

(ALL CLIENTS)

			-			-				
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SOCIAL SECURITY NUMBER DATA QUALITY

(ALL CLIENTS)

Full SSN reported

Approximate or partial SSN reported

Client doesn't know

Client refused

3.3 DATE OF BIRTH (e.g., 10/23/1978)

(ALL CLIENTS)

		/			/				
Month		Day			Year				

DATE OF BIRTH DATA QUALITY

(ALL CLIENTS)

Full date of birth reported

Approximate or partial date of birth reported

Client doesn't know

Client refused

3.4 RACE

(ALL CLIENTS)

Select one or more categories for Race based on how the client self-identifies. Staff observations should not be used to collect information on race.

American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or Other Pacific Islander

White

Client doesn't know

Client refused

3.5 ETHNICITY

(ALL CLIENTS)

Select Ethnicity based on whether or not the client identifies as Hispanic or Latino. The definition of Hispanic or Latino ethnicity is a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture of origin, regardless of race.

Non-Hispanic / Non-Latino

Hispanic / Latino

Client doesn't know

Client refused

3.6 GENDER

(ALL CLIENTS)

Gender should be assigned based on the client's self-perceived gender identity. Transgender is defined as identification with, or presentation as, a gender that is different from the gender at birth.

Male

Female

Transgender female to male

Transgender male to female

Doesn't identify as male, female or transgender

Client doesn't know

Client refused

4.30 PREGNANCY STATUS

(ALL FEMALE CLIENTS – HEAD OF HOUSEHOLD, ADULTS, AND UNACCOMPANIED YOUTH)

No

Client doesn't know

Yes

Client refused

If yes, Due Date

		/			/				
Month			Day			Year			

4.23 SEXUAL ORIENTATION

(HEAD OF HOUSEHOLD, ADULTS, AND UNACCOMPANIED YOUTH)

Heterosexual

Questioning / Unsure

Gay

Client doesn't know

Lesbian

Client refused

Bisexual

3.7 VETERAN STATUS

(ALL ADULTS)

Veteran Status is only collected on heads of household who are 18 years of age and older, as well as all other adults in the household.

No

Client doesn't know

Yes

Client refused

3.8 DISABLING CONDITION

(ALL CLIENTS)

Record whether the client has a disabling condition based on one or more of the following:

- A physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury that:
 - (1) Is expected to be long-continuing or of indefinite duration;
 - (2) Substantially impedes the individual's ability to live independently; and
 - (3) Could be improved by the provision of more suitable housing conditions.
- A developmental disability, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000(42 U.S.C. 15002); or
- The disease of acquired immunodeficiency syndrome (AIDS) or any condition arising from the etiologic agency for acquired immunodeficiency syndrome (HIV).

If the client is a veteran who is disabled by an injury or illness that was incurred or aggravated during active military service and whose disability meets the disability definition defined in Section 223 of the social security act, they should be identified as having a disabling condition.

No

Client doesn't know

Yes

Client refused

3.15 RELATIONSHIP TO HEAD OF HOUSEHOLD

(ALL CLIENTS)

Self (head of household)

Head of household's spouse

Head of household's son

Other family member

Head of household's daughter

Other Non-family member

Head of household's dependent child

**PRIOR ZIP CODE
(ALL CLIENTS)**

Prior Zip Code																
City																
State																

3.917B LIVING SITUATION – TYPE OF RESIDENCE – INSTITUTIONAL, TRANSITIONAL, OR PERMANENT HOUSING SITUATION

(HEAD OF HOUSEHOLD AND OTHER ADULTS ONLY)

Identify the type of residence and length of stay at that residence just prior to (i.e., the night before) program admission.

Complete this section if client's living situation prior to project entry was Literally Homeless

Homeless Situation	
<input type="checkbox"/>	Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)
<input type="checkbox"/>	Emergency shelter, including hotel or motel paid for <u>with</u> emergency shelter voucher
<input type="checkbox"/>	Safe Haven
<input type="checkbox"/>	Interim Housing

**LENGTH OF STAY IN PRIOR LIVING SITUATION
(HEAD OF HOUSEHOLD AND OTHER ADULTS ONLY)**

<input type="checkbox"/> One day or less	<input type="checkbox"/> More than three months, but less than one year
<input type="checkbox"/> Two days to one week	<input type="checkbox"/> One year or longer
<input type="checkbox"/> More than one week, but less than one month	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> One to three months	<input type="checkbox"/> Client refused

APPROXIMATE DATE HOMELESSNESS STARTED

		/			/				
Month		Day		Year					

REGARDLESS OF WHERE THEY STAYED LAST NIGHT – NUMBER OF TIMES THE CLIENT HAS BEEN ON THE STREETS, IN EMERGENCY SHELTER, OR SAFE HAVEN IN THE PAST THREE YEARS INCLUDING TODAY

<input type="checkbox"/> One time	<input type="checkbox"/> Four or more times
<input type="checkbox"/> Two times	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Three times	<input type="checkbox"/> Client refused

TOTAL NUMBER OF MONTHS HOMELESS ON THE STREET, IN EMERGENCY SHELTER, OR SAFE HAVEN IN THE PAST THREE YEARS

<input type="checkbox"/> One month (this time is the first month)	<input type="checkbox"/> 9 months
<input type="checkbox"/> 2 months	<input type="checkbox"/> 10 months
<input type="checkbox"/> 3 months	<input type="checkbox"/> 11 months
<input type="checkbox"/> 4 months	<input type="checkbox"/> 12 months
<input type="checkbox"/> 5 months	<input type="checkbox"/> More than 12 months
<input type="checkbox"/> 6 months	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> 7 months	<input type="checkbox"/> Client refused
<input type="checkbox"/> 8 months	

Complete this section if client's living situation prior to project entry was an Institutional Situation

Institutional Situation	
<input type="checkbox"/> Foster care home or foster care group home	<input type="checkbox"/> Long-term care facility or nursing home
<input type="checkbox"/> Hospital or other residential non-psychiatric medical facility	<input type="checkbox"/> Psychiatric hospital or other psychiatric facility
<input type="checkbox"/> Jail, prison, or juvenile detention facility	<input type="checkbox"/> Substance abuse treatment facility or detox center

- If Institutional Situation is selected above for Prior Living Situation, DID CLIENT STAY LESS THAN 90 DAYS?**

No Yes

- [IF NO] Answer this question, then skip to 4.4 Health Insurance.**

LENGTH OF STAY IN PRIOR LIVING SITUATION

<input type="checkbox"/> More than three months, but less than one year	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> One year or longer	<input type="checkbox"/> Client refused

- [IF YES] Answer this question and continue to next question**

LENGTH OF STAY IN PRIOR LIVING SITUATION

<input type="checkbox"/> One day or less	<input type="checkbox"/> One to three months
<input type="checkbox"/> Two days to one week	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> More than one week, but less than one month	<input type="checkbox"/> Client refused

ON THE NIGHT BEFORE DID CLIENT STAY ON THE STREETS, ES, OR SH?

No Yes

- [If NO] No further information is needed for this element - skip to 4.4 Health Insurance.**
- [If YES] APPROXIMATE DATE HOMELESSNESS STARTED**

		/			/				
Month			Day		Year				

REGARDLESS OF WHERE THEY STAYED LAST NIGHT – NUMBER OF TIMES THE CLIENT HAS BEEN ON THE STREETS, IN EMERGENCY SHELTER, OR SAFE HAVEN IN THE PAST THREE YEARS INCLUDING TODAY

<input type="checkbox"/> One time	<input type="checkbox"/> Four or more times
<input type="checkbox"/> Two times	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Three times	<input type="checkbox"/> Client refused

TOTAL NUMBER OF MONTHS HOMELESS ON THE STREET, IN EMERGENCY SHELTER, OR SAFE HAVEN IN THE PAST THREE YEARS

<input type="checkbox"/> One month (this time is the first month)	<input type="checkbox"/> 9 months
<input type="checkbox"/> 2 months	<input type="checkbox"/> 10 months
<input type="checkbox"/> 3 months	<input type="checkbox"/> 11 months
<input type="checkbox"/> 4 months	<input type="checkbox"/> 12 months
<input type="checkbox"/> 5 months	<input type="checkbox"/> More than 12 months
<input type="checkbox"/> 6 months	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> 7 months	<input type="checkbox"/> Client refused
<input type="checkbox"/> 8 months	

Complete this section if client's living situation prior to project entry was a Transitional or Permanent Housing situation

Transitional and Permanent Housing Situation	
<input type="checkbox"/> Hotel or motel paid for <u>without</u> emergency shelter voucher	<input type="checkbox"/> Rental by client, with other ongoing housing subsidy
<input type="checkbox"/> Owned by client, no ongoing housing subsidy	<input type="checkbox"/> Residential project or halfway house with no homeless criteria
<input type="checkbox"/> Owned by client, with ongoing housing subsidy	<input type="checkbox"/> Staying or living in a family member's room, apartment, or house
<input type="checkbox"/> Permanent housing for formerly homeless persons (such as CoC project)	<input type="checkbox"/> Staying or living in a friend's room, apartment, or house
<input type="checkbox"/> Rental by client, no ongoing housing subsidy	<input type="checkbox"/> Transitional housing for homeless persons (including homeless youth)
<input type="checkbox"/> Rental by client, with VASH subsidy	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Rental by client, with GPD TIP subsidy	<input type="checkbox"/> Client refused

• **If Transitional or Permanent Housing Situation is selected above for Prior Living Situation, DID CLIENT STAY LESS THAN 7 NIGHTS?**

No Yes

• **[IF NO] Answer this question, then skip to 4.4 Health Insurance**

LENGTH OF STAY IN PRIOR LIVING SITUATION

<input type="checkbox"/> More than one week, but less than one month	<input type="checkbox"/> One year or longer
<input type="checkbox"/> One to three months	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> More than three months, but less than one year	<input type="checkbox"/> Client refused

• **[IF YES] Answer this question and continue to next question**

LENGTH OF STAY IN PRIOR LIVING SITUATION

<input type="checkbox"/> One day or less	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Two days to one week	<input type="checkbox"/> Client refused

ON THE NIGHT BEFORE DID CLIENT STAY ON THE STREETS, ES, OR SH?

No Yes

• **[If NO] Skip to 4.4 Health Insurance**

• **[If YES] APPROXIMATE DATE HOMELESSNESS STARTED**

		/			/				
Month		Day		Year					

REGARDLESS OF WHERE THEY STAYED LAST NIGHT – NUMBER OF TIMES THE CLIENT HAS BEEN ON THE STREETS, IN EMERGENCY SHELTER, OR SAFE HAVEN IN THE PAST THREE YEARS INCLUDING TODAY

<input type="checkbox"/> One time	<input type="checkbox"/> Four or more times
<input type="checkbox"/> Two times	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Three times	<input type="checkbox"/> Client refused

TOTAL NUMBER OF MONTHS HOMELESS ON THE STREET, IN EMERGENCY SHELTER, OR SAFE HAVEN IN THE PAST THREE YEARS

- | | |
|---|--|
| <input type="checkbox"/> One month (this time is the first month) | <input type="checkbox"/> 9 months |
| <input type="checkbox"/> 2 months | <input type="checkbox"/> 10 months |
| <input type="checkbox"/> 3 months | <input type="checkbox"/> 11 months |
| <input type="checkbox"/> 4 months | <input type="checkbox"/> 12 months |
| <input type="checkbox"/> 5 months | <input type="checkbox"/> More than 12 months |
| <input type="checkbox"/> 6 months | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> 7 months | <input type="checkbox"/> Client refused |
| <input type="checkbox"/> 8 months | |
-

**4.4 HEALTH INSURANCE
(ALL CLIENTS)**

Is the client currently covered by health insurance?

No

Yes

Client doesn't know

Client refused



[IF YES] Answer 'Yes' or 'No' for each health insurance source.

Answer 'No' for sources that have been terminated, even if they were received in the past.

No	Yes	Type of health insurance
<input type="checkbox"/>	<input type="checkbox"/>	Private
<input type="checkbox"/>	<input type="checkbox"/>	Private - Employer
<input type="checkbox"/>	<input type="checkbox"/>	Private - Individual
<input type="checkbox"/>	<input type="checkbox"/>	Medicare
<input type="checkbox"/>	<input type="checkbox"/>	Medicaid (Medi-Cal)
<input type="checkbox"/>	<input type="checkbox"/>	State Children's Health Insurance Program S-CHIP
<input type="checkbox"/>	<input type="checkbox"/>	Military Insurance
<input type="checkbox"/>	<input type="checkbox"/>	Other Public
<input type="checkbox"/>	<input type="checkbox"/>	State Funded
<input type="checkbox"/>	<input type="checkbox"/>	Combined Children's Health Insurance / Medicaid Program
<input type="checkbox"/>	<input type="checkbox"/>	Indian Health Service (IHS)
<input type="checkbox"/>	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	No insurance

**4.10 ALCOHOL ABUSE PROBLEM
(ALL CLIENTS)**

Does the client currently have an alcohol abuse problem?

No

Yes

Client doesn't know

Client refused



[IF YES for alcohol abuse problem] Is client currently receiving services/treatment for this condition?

No

Yes

Client doesn't know

Client refused

[IF YES for alcohol abuse problem] Is the alcohol abuse problem expected to be of long-continued and indefinite duration and substantially impairs client's ability to live independently?

No

Yes

Client doesn't know

Client refused

[IF YES for alcohol abuse problem] Is documentation of the disability and severity on file?

No

Yes

**4.7 CHRONIC HEALTH CONDITION
(ALL CLIENTS)**

Does the client currently have a chronic health condition?

No

Yes

Client doesn't know

Client refused



[IF YES for chronic health condition] Is the client currently receiving services/treatment for this condition?

No

Yes

Client doesn't know

Client refused

[IF YES for chronic health condition] Is the chronic health condition expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

No

Yes

Client doesn't know

Client refused

[IF YES for chronic health condition] Is documentation of the disability and severity on file?

No

Yes

**4.6 DEVELOPMENTAL DISABILITY
(ALL CLIENTS)**

Does the client currently have a developmental disability?

No

Yes

Client doesn't know

Client refused



[IF YES for developmental disability] Is the client currently receiving services/treatment for this disability?

No

Yes

Client doesn't know

Client refused

[IF YES for developmental disability] Is the developmental disability expected to substantially impair the client's ability to live independently?

No

Yes

Client doesn't know

Client refused

[IF YES for developmental disability] Is documentation of the disability and severity on file?

No

Yes

**4.10 DRUG ABUSE PROBLEM
(ALL CLIENTS)**

Does the client currently have a drug abuse problem?

No

Yes

Client doesn't know

Client refused



[IF YES for drug abuse problem] Is client currently receiving services/treatment for this condition?

No

Yes

Client doesn't know

Client refused

[IF YES for drug abuse problem] Is the drug abuse problem expected to be of long-continued and indefinite duration and substantially impairs client's ability to live independently?

No

Yes

Client doesn't know

Client refused

[IF YES for drug abuse problem] Is documentation of the disability and severity on file?

No

Yes

**4.8 HIV/AIDS
(ALL CLIENTS)**

Does the client currently have HIV/AIDS?

No

Yes

Client doesn't know

Client refused



[IF YES for HIV/AIDS] Is the client currently receiving services/treatment for this condition?

No

Yes

Client doesn't know

Client refused

[IF YES for HIV/AIDS] Is HIV/AIDS expected to substantially impair the client's ability to live independently?

No

Yes

Client doesn't know

Client refused

[IF YES for HIV/AIDS] Is documentation of the disability and severity on file?

No

Yes

**4.9 MENTAL HEALTH ILLNESS
(ALL CLIENTS)**

Does the client currently have a mental health illness?

- No
 Yes

- Client doesn't know
 Client refused



[IF YES for mental health illness] Is the client currently receiving services/treatment for this condition?

- No
 Yes

- Client doesn't know
 Client refused

[IF YES for mental health illness] Is the mental health illness expected to be of long-continued and indefinite duration and substantially impairs the client's ability to live independently?

- No
 Yes

- Client doesn't know
 Client refused

[IF YES for mental health illness] Is documentation of the disability and severity on file?

- No
 Yes

**4.5 PHYSICAL DISABILITY
(ALL CLIENTS)**

Does the client currently have a physical disability?

- No
 Yes

- Client doesn't know
 Client refused



[IF YES for physical disability] Is the client currently receiving services/treatment for this disability?

- No
 Yes

- Client doesn't know
 Client refused

[IF YES for physical disability] Is the physical disability expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

- No
 Yes

- Client doesn't know
 Client refused

[IF YES for physical disability] Is documentation of the disability and severity on file?

- No
 Yes

4.2 INCOME AND SOURCES
(HEAD OF HOUSEHOLD AND OTHER ADULTS ONLY)

Income from any source?

No
 Yes

Client doesn't know
 Client refused



[IF YES] Answer Yes or No for each income source. If the response for a source is 'Yes', enter the monthly amount received based on current income. If unsure of the exact monthly amount, enter client's best estimate.

Source of income	Receiving income from source?	If yes, monthly amount from source (round to nearest dollar)		
Earned income (i.e., employment income)	No	<input type="checkbox"/>		
	Yes	<input type="checkbox"/>	\$. 0 0
Unemployment Insurance	No	<input type="checkbox"/>		
	Yes	<input type="checkbox"/>	\$. 0 0
Supplemental Security Income (SSI)	No	<input type="checkbox"/>		
	Yes	<input type="checkbox"/>	\$. 0 0
Social Security Disability Income (SSDI)	No	<input type="checkbox"/>		
	Yes	<input type="checkbox"/>	\$. 0 0
Veteran's Disability Payment	No	<input type="checkbox"/>		
	Yes	<input type="checkbox"/>	\$. 0 0
Private Disability Insurance	No	<input type="checkbox"/>		
	Yes	<input type="checkbox"/>	\$. 0 0
Worker's Compensation	No	<input type="checkbox"/>		
	Yes	<input type="checkbox"/>	\$. 0 0
Temporary Assistance for Needy Families (TANF)	No	<input type="checkbox"/>		
	Yes	<input type="checkbox"/>	\$. 0 0
General Assistance (GA)	No	<input type="checkbox"/>		
	Yes	<input type="checkbox"/>	\$. 0 0
Retirement (Social Security)	No	<input type="checkbox"/>		
	Yes	<input type="checkbox"/>	\$. 0 0
Veteran's Pension	No	<input type="checkbox"/>		
	Yes	<input type="checkbox"/>	\$. 0 0
Other Pension	No	<input type="checkbox"/>		
	Yes	<input type="checkbox"/>	\$. 0 0
Child Support	No	<input type="checkbox"/>		
	Yes	<input type="checkbox"/>	\$. 0 0
Alimony	No	<input type="checkbox"/>		
	Yes	<input type="checkbox"/>	\$. 0 0
Other Income If yes, specify	No	<input type="checkbox"/>		
	Yes	<input type="checkbox"/>	\$. 0 0
Total monthly income	Monthly income from all sources		\$. 0 0

4.3 NON-CASH BENEFITS
(HEAD OF HOUSEHOLD AND OTHER ADULTS ONLY)

Non-cash benefits from any source?

No

Yes

Client doesn't know

Client refused



[IF YES] Answer 'Yes' or 'No' for each non-cash benefit source. (Answer 'No' for benefits that have been terminated, even if they were received in the past.) If unsure of the exact monthly amount, enter client's best estimate.

Source of non-cash benefit	Receiving benefit from source?	If yes, monthly amount from source (round to nearest dollar)			
Food Stamps / Supplemental Nutrition Assistance Program (SNAP)	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
MEDICAID (Medi-Cal)	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>			
MEDICARE	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>			
State Children's Health Insurance Program	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>			
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>			
Veteran's Administration Medical Services	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>			
TANF Child Care Services	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>			
TANF Transportation Services	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>			
Other TANF-Funded Services	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>			
Section 8, Public Housing, or Other Rental Assistance	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>			
Other source: _____	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>			

4.26 EMPLOYMENT STATUS

(HEAD OF HOUSEHOLD AND OTHER ADULTS AND UNACCOMPANIED YOUTH)

Check the appropriate employment status at the time of assessment. If the client is employed, record the hours worked in the week prior to assessment, and select the tenure of the employment position. If the client is not employed, indicate if the client is looking for work.

- No
- Yes

- Client doesn't know
- Client refused



[IF YES] Type of Employment

- Full-time
- Part-Time
- Seasonal / sporadic (including day labor)



Hours worked last week

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Employment Tenure

- Permanent
- Temporary
- Seasonal

- Client doesn't know
- Client refused

[IF NO] Why not employed?

- Looking for work
- Unable to work
- Not looking for work

LAST GRADE COMPLETED AND SCHOOL STATUS

(HEAD OF HOUSEHOLD AND OTHER ADULTS AND UNACCOMPANIED YOUTH)

Indicate if the client is currently enrolled in an education or training program or working toward a degree at the time of assessment. Indicate if the client has completed vocational training or received an apprenticeship. Select highest grade completed. If the client has completed a high school diploma or above, select the secondary education degree(s) the client has earned.

4.24 Highest grade completed

- School program does not have grade levels
- Less than Grade 5
- Grades 5-6
- Grades 7-8
- 9th Grade
- 10th Grade
- 11th Grade
- 12th Grade, No diploma
- High school diploma

- GED
- Some college
- Associates degree
- Bachelor's degree
- Graduate degree
- Vocational certification
- Client doesn't know
- Client refused

4.25 Attendance status

- Attending school regularly
- Attending school irregularly
- Graduated from high school
- Obtained GED
- Dropped out

- Suspended
- Expelled
- Client doesn't know
- Client refused

HEALTH ASSESSMENT (HEAD OF HOUSEHOLD AND OTHER ADULTS AND UNACCOMPANIED YOUTH)

4.27 General Health Status

- Excellent
- Very Good
- Good
- Fair

- Poor
- Client doesn't know
- Client refused

4.28 Dental Health Status

- Excellent
- Very Good
- Good
- Fair

- Poor
- Client doesn't know
- Client refused

4.29 Mental Health Status

- Excellent
- Very Good
- Good
- Fair

- Poor
- Client doesn't know
- Client refused

**RHY ENTRY ASSESSMENT
(HEAD OF HOUSEHOLD AND OTHER ADULTS AND UNACCOMPANIED YOUTH)**

4.34 Referral Source

- | | |
|---|---|
| <input type="checkbox"/> Self-Referral | <input type="checkbox"/> Residential Project: Drug Treatment Center |
| <input type="checkbox"/> Individual: Parent/Guardian | <input type="checkbox"/> Residential Project: Treatment Center |
| <input type="checkbox"/> Individual: Relative or Friend | <input type="checkbox"/> Residential Project: Educational Institute |
| <input type="checkbox"/> Individual: Other Adult or Youth | <input type="checkbox"/> Residential Project: Other Agency Project |
| <input type="checkbox"/> Individual: Partner/Spouse | <input type="checkbox"/> Residential Project: Other Project |
| <input type="checkbox"/> Individual: Foster Parent | <input type="checkbox"/> Hotline: National Runaway Switchboard |
| <input type="checkbox"/> Outreach Project: FYSB | <input type="checkbox"/> Hotline: Other |
| <input type="checkbox"/> Outreach Project: Other | <input type="checkbox"/> Other Agency: Child Welfare / CPS |
| <input type="checkbox"/> Temporary Shelter: FYSB Basic Center Project | <input type="checkbox"/> Other Agency: Non-Residential Independent Living Project |
| <input type="checkbox"/> Temporary Shelter: Other Youth Only Emergency Shelter | <input type="checkbox"/> Other Project Operated by your Agency |
| <input type="checkbox"/> Temporary Shelter: Emergency Shelter for Families | <input type="checkbox"/> Other Youth Services Agency |
| <input type="checkbox"/> Temporary Shelter: Emergency Shelter for Individuals | <input type="checkbox"/> Juvenile Justice |
| <input type="checkbox"/> Temporary Shelter: Domestic Violence Shelter | <input type="checkbox"/> Law Enforcement / Police |
| <input type="checkbox"/> Temporary Shelter: Safe Place | <input type="checkbox"/> Religious Organization |
| <input type="checkbox"/> Temporary Shelter: Other | <input type="checkbox"/> Mental Hospital |
| <input type="checkbox"/> Residential Project: FYSB Transitional Living Project | <input type="checkbox"/> School |
| <input type="checkbox"/> Residential Project: Other Transitional Living Project | <input type="checkbox"/> Other Organization |
| <input type="checkbox"/> Residential Project: Group Home | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Residential Project: Independent Living Project | <input type="checkbox"/> Client refused |
| <input type="checkbox"/> Residential Project: Job Corps | |

**4.35A COMMERCIAL SEXUAL EXPLOITATION
(HEAD OF HOUSEHOLD AND OTHER ADULTS AND UNACCOMPANIED YOUTH)**

Ever received anything in exchange for sex (e.g. money, food, drugs, shelter)

<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> Client refused



[IF YES to Commercial Sexual Exploitation] In the last three months

<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> Client refused



How many times?

<input type="checkbox"/> 1-3	<input type="checkbox"/> 12 or more
<input checked="" type="checkbox"/> 4-7	<input type="checkbox"/> Client refused
<input type="checkbox"/> 8-11	<input type="checkbox"/> Client doesn't know



Ever made/persuaded to have sex in exchange for something

<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> Client refused



[IF YES] In the last three months

<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> Client refused

**4.35B COMMERCIAL LABOR EXPLOITATION
(HEAD OF HOUSEHOLD AND OTHER ADULTS AND UNACCOMPANIED YOUTH)**

Ever afraid to quit/leave work due to threats of violence to yourself, family, or friends

<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> Client refused



[IF YES] Felt forced, pressured or tricked into continuing the job

<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> Client refused



In the last three months

<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> Client refused

Ever promised work where work or payment different than you expected?

<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> Client refused



[IF YES] Felt forced, pressured or tricked into continuing the job

No

Client doesn't know

Yes

Client refused



In the last three months

No

Client doesn't know

Yes

Client refused

**4.33 YOUNG PERSON'S CRITICAL ISSUES
(HEAD OF HOUSEHOLD AND OTHER ADULTS AND UNACCOMPANIED YOUTH)**

Critical Issue

Status

Household Dynamics	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sexual Orientation / Gender Identity – Youth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sexual Orientation / Gender Identity – Family member	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Housing Issues – Youth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Housing Issues – Family member	<input type="checkbox"/> Yes	<input type="checkbox"/> No
School or Educational Issues – Youth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
School or Educational Issues – Family member	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unemployment – Youth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unemployment – Family member	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mental Health Issues – Youth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mental Health Issues – Family member	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Health Issues – Youth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Health Issues – Family member	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physical Disability – Youth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physical Disability – Family member	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mental Disability – Youth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mental Disability – Family member	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abuse and Neglect – Youth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abuse and Neglect – Family member	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcohol or other drug abuse – Youth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcohol or other drug abuse – Family member	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Insufficient Income to support youth – Family member	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Active Military Parent – Family member	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Incarcerated Parent of Youth	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**4.31 FORMERLY WARD OF CHILD WELFARE / FOSTER CARE AGENCY
(HEAD OF HOUSEHOLD AND OTHER ADULTS AND UNACCOMPANIED YOUTH)**

<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> Client refused



[IF YES] Number of years

<input type="checkbox"/> Less than one year
<input checked="" type="checkbox"/> 1 to 2 years
<input type="checkbox"/> 3 to 5 or more years



[IF LESS THAN ONE YEAR] Number of months (1-11)

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**4.32 FORMERLY WARD OF JUVENILE JUSTICE SYSTEM
(HEAD OF HOUSEHOLD AND OTHER ADULTS AND UNACCOMPANIED YOUTH)**

<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> Client refused



[IF YES] Number of years

<input type="checkbox"/> Less than one year
<input checked="" type="checkbox"/> 1 to 2 years
<input type="checkbox"/> 3 to 5 or more years



[IF LESS THAN ONE YEAR] Number of months (1-11)

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