HHS RHY Emergency Shelter and Street Outreach Assessment (Single Youth or Head of Household)

Client Name: ____________________________________  HMIS Client ID#: ________________________
(optional)
Annual/ Update Assessment Date: _______________________

Client Location: ____ NY-505 (Onondaga/ Cayuga/ Oswego counties)
____ NY-510 (Ithaca/ Tompkins County)

Income:
Do you have income?  ____Yes  ____No  Total Monthly Income $________
Income Source and amount:
_____ Alimony/ Spousal Support  _____ Child Support
_____ Earned Income  _____ General Assistance
_____ Pension or retirement income from another job
_____ Private Disability Insurance  _____ Retirement Income from Social Security
_____ Social Security Disability Income (SSDI)  _____ Social Security Income (SSI)
_____ Temporary Assistance for Needy Families TANF  _____ Unemployment Insurance
_____ VA Non-Service-Connected Disability Pension  _____ VA Service-Connected Disability Compensation
_____ Worker’s Compensation

Non-Cash Benefits:
Do you have Non-Cash Benefits?  ____Yes  ____No  Monthly Amount $________
Source of Non-Case Benefits:
_____ Supplemental Nutrition Assistance Program (SNAP) (HUD) (Previously known as Food Stamps)
_____ Special supplemental Nutrition Program for (WIC) (HUD)
_____ TANF Child Care Services (HUD)
_____ TANF Transportation Services (HUD)
_____ Other TANF-Funded Services (HUD);  If “Other” Specify: ___________________________________

Medical Insurance:
Do you have Health Insurance/ Medical Assistance?  ____Yes  ____No
Source of Health Insurance/ Medical Assistance:
_____ Medicaid  _____ Medicare
_____ State Children’s Health Insurance Program  _____ Veteran’s Administration (VA) Medical Services
_____ Employer – Provided Health Insurance  _____ Health Insurance obtained through COBRA
_____ State Health Insurance for Adults
_____ Indian Health Care  _____ Other

Medicaid ID# _______________________________________
Medicaid Insurance Company:  _____ Total Care  _____ Blue Cross Blue Shield  _____ Fidelis
_____ United Healthcare  _____ Molina Healthcare

Disabling Condition:
Do you have a DISABILITY of long duration?  _____Yes  _____ No
For each disability, check “LCI” if it is expected to be of long, continued and indefinite duration, substantially impairs the individual’s ability to live independently, and is of such a nature that such ability could be improved by more suitable housing conditions.

**Disability Type:**
- Yes__LCI Alcohol Use Disorder  
- Yes__LCI BOTH Alcohol & Drug Use Disorder  
- Yes__LCI Drug Use Disorder  
- Yes__LCI Chronic Health Condition  
- Yes__LCI Developmental  
- ____HIV/AIDS
- Yes__LCI Mental Health Disorder  
- Yes__LCI Physical Health

**Current Living Situation:** (Street Outreach ONLY)
Start Date: ___/___/______  End Date: ___/___/______  Information Date: ___/___/______

**Current Living Situation:**
Homeless Situation (chose only one):
- Place not meant for human habitation
- Emergency shelter, including hotel or motel paid for with emergency shelter voucher
- Safe Haven
- Interim Housing

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

Transitional and Permanent Housing Situation:
- Hotel or motel paid without emergency voucher
- Owned by client, no on-going housing subsidy
- Owned by client, with on-going housing subsidy
- Permanent housing (other than RRH) for formerly homeless persons
- Rental by client, no ongoing housing subsidy
- Rental by client, with VASH Subsidy
- Rental by client, with GPD TIP subsidy
- Rental by client, with other ongoing housing subsidy
- Residential project or halfway house with no homeless criteria
- Staying in family member’s room/apartment/house
- Staying in friend’s room/apartment/house
- Transitional housing for homeless persons (including homeless youth)

Other:
- Other
- Worker unable to determine
___Client Doesn’t Know
___Client Refused
___Data Not Collected

If “Other,” specify: ________________________________________________

Living Situation Verified By: __________________ (CoC Code)

Is client going to have to leave their current living situation within 14 days? ____Yes ____ No

If ‘Yes’ to “Is client going to have to leave their current living situation within 14 days?” answer the following questions:

Has a subsequent residence been identified? ____Yes ____ No

Does individual or family have resources or support networks to obtain other permanent housing? ____Yes ____ No

Has the client had a lease or ownership interest in permanent housing unit in the last 60 days? ____Yes ____ No

Has the client moved 2 or more times in the last 60 days? ____Yes ____ No

Date of Engagement: ___/___/____ (Complete upon client entering Service Plan development or fully completed initial assessment)

Pregnant? ____Yes ____ No  If yes, Projected Birth Date: ___/___/____