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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 Assist 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:

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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

<u>Current Living Situation: (Street Outreach ONLY)</u>
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

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____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: ____/____/______