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

Client Name: _____ HMIS Client ID#: _____
(optional)
Project Start Date: _____ **ROI Signed?** Yes ____ No ____
SS#: _ _ _ - _ _ - _ _ _ _ **DOB**___/___/_____ **Veteran?** Yes ____ No_____

Race: (Select as many as client identifies)
____ American Indian/ Alaska Native or Indigenous
____ Asian or Asian American
____ Black, African American, or African
____ Native Hawaiian or Pacific Islander
____ White

Ethnicity: ____ Hispanic/ Latin(a)(o)(x)
____ Non-Hispanic/ Latin(a)(o)(x)

Gender: (Select as many as client identifies)
____ Female
____ Male
____ Transgender (clients who live or identify with a transgender history, experience, or identity)

____ A gender that is not singularly 'Female' or 'Male' (e.g., non-binary, genderfluid, agender, culturally specific gender)
____ Questioning (Unsure, ay be exploring, or may not relate to or identify with a gender identity at this time)

Relationship to Head of Household:
____ Self (Head of Household)
____ Head of Household's Child
____ Head of Household's Spouse/ Partner
____ Head of Household's Other Relation Member
____ Other: Non-Relation Member

Primary Language: ____Arabic ____Armenian ____Bangali ____Catonese ____Chinese ____English ____French ____French Creole ____German ____Greek ____Gujarati ____Hatian Creole ____Hebrew____Hindi ____Hmong ____Italian ____Japanese ____Korean ____Mandarin ____Panjabi ____Persian ____Polish ____Portuguese ____Russian ____Spanish ____Tagalog ____Telugu ____Urdu ____Vietnamese ____Yiddish

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

<u>Medical Insurance:</u>
Do you have Health Insurance/ Medical Assistance? ____Yes ____ No
Source of Health Insurance/ Medical Assistance:
_____ Medicaid _____ Medicare

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_____ State Children's Health Insurance Program
_____ Employer – Provided Health Insurance
_____ State Health Insurance for Adults
_____ Indian Health Care _____ Other
_____ Veteran's Administration (VA) Medical Services
_____ Health Insurance obtained through COBRA

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

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

Referral Source:

____ Self-Referral ____ Outreach Provider ____ Temporary Shelter ____ Residential Project
____ Individual: Parent/ Guardian/ Relative/ Friend/ Foster Parent/ Other Individual
____ Hotline ____ Child Welfare/ CPS ____ Juvenile Justice ____ Mental Hospital
____ Law Enforcement/ Police ____ School ____ Other Organization

If Outreach Project is selected, Number of times approached by outreach prior to entering the project:
_____

Date of BCP Status**: ___/___/___**

Youth Eligible for RHY Services: ____Yes ____ No

If no for "Youth Eligible for RHY Services," Reason why services are not funded by BCP grant:

____ Out of Range ____ Ward of the State – Immediate Reunification
____ Ward of Criminal Justice System – Immediate Reunification
____ Other: _____

If yes for "Youth Eligible for RHY Services," runaway youth: ____Yes ____ No

Sexual Orientation:

____ Heterosexual ____ Gay ____ Lesbian ____ Bisexual ____ Questioning/ Unsure

Last Grade Completed:

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____ Less than Grade 5 ____ Grades 5-6 ____ Grades 7-8 ____ Grades 9-11
____ Grades 12/ HS Diploma ____ School Program Doesn't have grade levels
____ GED ____ Some College ____ Associates Degree ____ Bachelor's Degree
____ Graduate Degree ____ Vocational Certification

School Status:
____ Attending School Regularly ____ Attending School Irregularly ____ Graduated Already
____ Obtained GED ____ Dropped out ____ Suspended
____ Expelled

Employment History:
Employed? ____Yes ____ No If yes, Type of Enrollment: ___ Full time ____ Part time ____ Seasonal/ sporadic
If no, why not employed? ____ Looking for work ____ Unable to work ____ Not looking for work

General Health Status:
____ Excellent ____ Very Good ____ Good ____ Fair ____ Poor

Mental Health Status:
____ Excellent ____ Very Good ____ Good ____ Fair ____ Poor

Dental Health Status:
____ Excellent ____ Very Good ____ Good ____ Fair ____ Poor

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

Formerly a Ward of the Child Welfare/ Foster Care Agency? ____Yes ____ No
Number of Years: ____ Less than one year ____ 1 to 2 years ____ 3 to 5 years or more
If less than One year, number of months: _____ months

Formerly a Ward of the Juvenile Justice System? ____Yes ____ No
Number of Years: ____ Less than one year ____ 1 to 2 years ____ 3 to 5 years or more
If less than One year, number of months: _____ months

Family Critical Issues:
Under Employment – Family member? ____Yes ____ No
Mental Health Issues – Family member? ____Yes ____ No
Physical Disability – Family member? ____Yes ____ No
Alcohol or Substance Abuse – Family member? ____Yes ____ No
Insufficient Income to support youth – Family member? ____Yes ____ No
Incarcerated Parent of Youth? ____Yes ____ No