

HHS RHY Entry for SO and ES 2020

Please complete one sheet for each person served, whether they are an individual or a family member

Project Start Date: ____/____/____ **Project Name:** _____

ServicePointClient ID _____

First Name: _____ **MI:** _____ **Last Name:** _____ **Suffix:** _____

Name Type: Full Name Reported
 Partial, Street Name, or Code Name Reported
 Client Doesn't Know
 Client Refused
 Data Not Collected

SSN: _____ - _____ - _____ **SSN Type:** Full
 Approximate/Partial
 Client Doesn't Know
 Client Refused
 Data Not Collected

U.S. Military Veteran? (clients 18 and older): Yes No Client Doesn't Know Client Refused Data Not Collected

DOB(mm/dd/yyyy) ____/____/____ **DOB Type:** Full DOB
 Approximate or Partial DOB
 Client Doesn't Know
 Client Refused
 Data Not Collected

Primary Race: American Indian or Alaska Native White
 Asian Client Doesn't know
 Black/African American Client Refused
 Native Hawaiian or Other Pacific Islander Data Not Collected

Secondary Race: American Indian or Alaska Native White
 Asian Client Doesn't know
 Black/African American Client Refused
 Native Hawaiian or Other Pacific Islander Data Not Collected

Ethnicity: Non-Hispanic /Latino
 Hispanic/Latino
 Client Doesn't Know
 Client Refused
 Data Not Collected

Gender: Female Gender non-conforming {IE not exclusively male or female}
 Male Client Doesn't Know
 Trans Female (MTF male to female) Client Refused
 Trans Male (FTM or female to male) Data Not Collected

Do you have a disabling condition? Yes No Client Doesn't Know Client Refused Data Not Collected

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- Relationship to Head of Household:**
- Self
 - Head of Household's Child
 - Head of Household's Spouse or Partner
 - Head of Household's other relation member
 - Other non-relation member
 - Data Not Collected

Prior Living Situation:

-HOMELESS SITUATIONS-

- Place Not Meant for Habitation
- Emergency Shelter, including hotel/motel paid for w/ES voucher, or RHY-funded host home shelter
- Safe Haven

-INSTITUTIONAL SITUATIONS-

- Foster Care Home or 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 or Detox Center

-TEMPORARY AND PERMANENT HOUSING SITUATIONS-

- Residential Project or Halfway House with no Homeless Criteria
- Hotel or Motel Paid for without an Emergency Shelter Voucher
- Transitional Housing for Homeless Persons (includes homeless youth)
- Host Home (non-crisis)
- Staying or Living in a Friend's Room, Apartment or House
- Staying or Living in a Family Member's Room, Apartment or House
- Rental by Client, with GPD TIP Housing Subsidy
- Rental by Client, with VASH Housing Subsidy
- Permanent Housing (other than RRH) for Formerly Homeless Persons
- Rental by Client, with RRH or Equivalent Subsidy
- Rental by Client, with HCV voucher (tenant or project based)
- Rental by Client in a Public Housing Unit
- Rental by Client, No Ongoing Housing Subsidy
- Rental by Client, with Other Ongoing Housing Subsidy
- Owned by Client, with Ongoing Housing Subsidy
- Owned by Client, No Ongoing Housing Subsidy

-OTHER-

- Client Doesn't Know
- Client Refused
- Data Not Collected

- Length of stay in previous place:**
- | | |
|---|--|
| <input type="checkbox"/> One night or less | <input type="checkbox"/> one year or longer |
| <input type="checkbox"/> Two to six nights | <input type="checkbox"/> Client Doesn't Know |
| <input type="checkbox"/> One week or more but less than one month | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> One month or more but less than 90 days | <input type="checkbox"/> Data Not Collected |
| <input type="checkbox"/> 90 days or more but less than one year | |

Approximate Date Homelessness Started: _____/_____/_____

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Regardless of where they stayed last night - Number of times the client has been on the streets, in ES, or SH in the past three years including today:

- | | |
|---|--|
| <input type="checkbox"/> One Time | <input type="checkbox"/> Client Doesn't Know |
| <input type="checkbox"/> Two Times | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Three Times | <input type="checkbox"/> Data Not Collected |
| <input type="checkbox"/> Four or More Times | |

Total Number of Months Homeless on the street, in ES or SH in the Past Three Years:

- | | | |
|---|------------------------------------|--|
| <input type="checkbox"/> One Month (this time is the first month) | <input type="checkbox"/> 6 Months | <input type="checkbox"/> 11 Months |
| <input type="checkbox"/> 2 Months | <input type="checkbox"/> 7 Months | <input type="checkbox"/> 12 Months |
| <input type="checkbox"/> 3 Months | <input type="checkbox"/> 8 Months | <input type="checkbox"/> More than 12 Months |
| <input type="checkbox"/> 4 Months | <input type="checkbox"/> 9 Months | <input type="checkbox"/> Client Doesn't Know |
| <input type="checkbox"/> 5 Months | <input type="checkbox"/> 10 Months | <input type="checkbox"/> Client Refused |
| | | <input type="checkbox"/> Data Not Collected |

Non-Cash Benefit from any source? Yes No Client Doesn't Know Client Refused Data Not Collected

Non-Cash Benefits

| Receiving Benefit | Source of Non-Cash Benefit <i>(Check all that apply)</i> | Benefit Amount <i>(when applicable)</i> |
|--|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Supplemental Nutrition Assistance Program (SNAP – Food Stamps) | \$ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Supplemental Nutrition Program for Women, Infants and Children (WIC) | \$ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | TANF Child Care services | \$ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | TANF Transportation services | \$ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Other TANF-funded services | \$ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Other Source – Specify Source _____ | \$ |

Covered by Health Insurance? Yes No Client Doesn't Know Client Refused Data Not Collected

Health Insurance

| Covered | Health Insurance Type <i>(Check all that apply)</i> |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | MEDICAID |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | MEDICARE |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | State Children's Health Insurance Program |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Veteran's Administration (VA) Medical Services |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Employer-Provided Health Insurance |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Health Insurance obtained through COBRA |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Private Pay Health Insurance |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | State Health Insurance for Adults |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Indian Health Services Program |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Other – Specify: _____ |

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Health, Substance Abuse, and Disabilities

| Disability Type | If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently |
|--|--|
| Physical <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC |
| Developmental <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC | Not Required <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC |
| Chronic Health Condition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC |
| HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC | Not Required <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC |
| Mental Health Problem <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC |
| Alcohol Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC |
| Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC |
| Both Alcohol and Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> DNC |

Current Living Situation Sub-Assessment (for Street Outreach Only):

Start Date: _____/_____/_____

End Date: _____/_____/_____

Information Date: _____/_____/_____

Current Living Situation:

-HOMELESS SITUATIONS-

- Place Not Meant for Habitation
- Emergency Shelter, including hotel/motel paid for w/ES voucher, or RHY-funded host home shelter
- Safe Haven

-INSTITUTIONAL SITUATIONS-

- Foster Care Home or Foster Care Group Home

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- Rental by Client in a Public Housing Unit
- Rental by Client, No Ongoing Housing Subsidy
- Rental by Client, with Other Ongoing Housing Subsidy
- Owned by Client, with Ongoing Housing Subsidy
- Owned by Client, No Ongoing Housing Subsidy

-OTHER-

- Other, Specify: _____
- Worker unable to determine
- Client Doesn't Know
- Client Refused
- Data Not Collected

Date of Engagement (for Street Outreach Only): _____/_____/_____

Referral Source:

- | | | |
|---|---|--|
| <input type="checkbox"/> Self-Referral | <input type="checkbox"/> Child Welfare/CPS | <input type="checkbox"/> Hotline |
| <input type="checkbox"/> Outreach Project | <input type="checkbox"/> Juvenile Justice | <input type="checkbox"/> Other Organization |
| <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 Refused |
| <input type="checkbox"/> Individual: Parent/Guardian/Relative/Friend/ Foster Parent/Other Individual | <input type="checkbox"/> School | <input type="checkbox"/> Data Not Collected |

Youth Eligible for RHY Services: Yes No

If No for "Youth Eligible for RHY Services", reason why services are not funded by BCP Grant:

- | | |
|---|--|
| <input type="checkbox"/> Out of Age Range | <input type="checkbox"/> Ward of the Criminal Justice System – Immediate Reunification |
| <input type="checkbox"/> Other | <input type="checkbox"/> Ward of the State – Immediate Reunification |

If Yes for "Youth Eligible for RHY Services", Runaway 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 Refused | |

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Sexual Orientation:

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Heterosexual | <input type="checkbox"/> Bisexual | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Gay | <input type="checkbox"/> Questioning/Unsure | <input type="checkbox"/> Data Not Collected |
| <input type="checkbox"/> Lesbian | <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Other, Describe: _____ |

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"/> Some College | <input type="checkbox"/> Vocational Certification |
| <input type="checkbox"/> Grades 7-8 | <input type="checkbox"/> Associate's Degree | <input type="checkbox"/> Client Doesn't Know |
| <input type="checkbox"/> Grades 9-11 | <input type="checkbox"/> Bachelor's Degree | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Grade 12/High School Diploma | | <input type="checkbox"/> Data Not Collected |

School Status:

- | | |
|---|--|
| <input type="checkbox"/> Attending School Regularly | <input type="checkbox"/> Suspended |
| <input type="checkbox"/> Attending School Irregularly | <input type="checkbox"/> Expelled |
| <input type="checkbox"/> Graduated High School | <input type="checkbox"/> Client Doesn't Know |
| <input type="checkbox"/> Obtained GED | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Dropped Out | <input type="checkbox"/> Data Not Collected |

Employed?: Yes No Client Doesn't Know Client Refused Data Not Collected

If Yes, Type of Employment:

- Full Time
- Part Time
- Seasonal/Sporadic (Including Day Labor)
- Data Not Collected

If No, Why not employed?

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

General Health Status:

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Poor |
| <input type="checkbox"/> Very Good | <input type="checkbox"/> Client Doesn't Know |
| <input type="checkbox"/> Good | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Fair | <input type="checkbox"/> Data Not Collected |

Dental Health Status:

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Poor |
| <input type="checkbox"/> Very Good | <input type="checkbox"/> Client Doesn't Know |
| <input type="checkbox"/> Good | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Fair | <input type="checkbox"/> Data Not Collected |

Mental Health Status:

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Poor |
| <input type="checkbox"/> Very Good | <input type="checkbox"/> Client Doesn't Know |
| <input type="checkbox"/> Good | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Fair | <input type="checkbox"/> Data Not Collected |

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Pregnancy Status: Yes No Client Doesn't Know Client Refused Data Not Collected

If Yes, Projected Birth Date?: _____

Formerly a Ward of Child Welfare/Foster Care Agency:

Yes No Client Doesn't Know Client Refused Data Not Collected

Number of Years: Less than 1 Year 1-2 Years 3-5 or more Years Data Not Collected

If less than 1 year, number of months: _____

Formerly a Ward of Juvenile Justice System: Yes No Client Doesn't Know Client Refused Data Not Collected

Number of Years: Less than 1 Year 1-2 Years 3-5 or more Years Data Not Collected

If less than 1 year, number of months: _____

Family Critical Issues:

Unemployment – Family Member: Yes No Data Not Collected

Mental Health Issues – Family Member: Yes No Data Not Collected

Physical Disability – Family Member: Yes No Data Not Collected

Alcohol or Substance Abuse – Family Member: Yes No Data Not Collected

Insufficient Income to Support Youth – Family Member: Yes No Data Not Collected

Incarcerated Parent of Youth: Yes No Data Not Collected

Maine Required Data Elements Assessment:

Zip Code of Last Permanent Address: _____

Zip data quality for last permanent address: Full or Partial Zip Code Report Client Doesn't know Client Refused

Release of Information Date: _____/_____/_____

Type of Release: None Signed by Client Verbal