

Collection Point: Entry
Projects/grants: RHY
Clients who are: Children (Under 18, Not HoH)

**Step 1: Client Demographics** - all fields with an "\*" are required.

First Name:\* \_\_\_\_\_ Last Name:\* \_\_\_\_\_

Middle Name: \_\_\_\_\_ Suffix: \_\_\_\_\_ HoH:\* \_\_\_\_\_

**Name Data Quality:\***

Full Name Reported

Partial, or Street Name

Client Doesn't Know

Client Refused

Data Not Collected

**Social Security Number:\*** \_\_\_\_\_

Full SSN Reported

Approximate or Partial SSN

Client Doesn't Know

Client Refused

Data Not Collected

**Birthdate:\*** \_\_\_\_\_

Full DOB Reported

Approximate or Partial DOB

Client Doesn't Know

Client Refused

Data Not Collected

**Ethnicity:\***

Hispanic/Latino

Non-Hispanic/Latino

Client Doesn't Know

Client Refused

Data Not Collected

**Race:\*** (Select all that apply)

American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or Other Pacific Islander

White

Client Doesn't Know

Client Refused

Data Not Collected

**Gender:\***

Male

Female

Transgender Female to Male

Transgender Male to Female

Client Doesn't Identify Male, Female, or Transgender

Client Doesn't Know

Client Refused

Data Not Collected

**If Female, Pregnancy Status:\***

Yes Due Date: \_\_\_\_\_

No

Client Doesn't Know

Client Refused

Data Not Collected

**Relationship to Head of Household:\***

Son

Daughter

Dependent Child

Spouse

Foster Child

Grandchild

Other Family Member

Other Non-Family Member

**Step 2: Project Enrollment**

Project Start Date:\* \_\_\_\_\_ Case Manager: \_\_\_\_\_

**Step 3: Entry Assessments**

**Disabling Condition:\***

Yes

No

Client Doesn't Know

Client Refused

Data Not Collected

**Health Insurance**

No Health Insurance

Client Refused

Client Doesn't Know

Data Not Collected

**If client has Health Insurance, check all that apply below:**

Private

Private - Employer

Private - Individual

Medicare

Medicaid

State Children's Health Insurance Program S-CHIP

Military Insurance


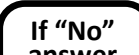
State Funded

Combined Children's Health Insurance/Medicaid Program






Indian Health Service (IHS)

**Step 4: BCP Status:\*** (BCP Projects Only) This element is required to be completed before project exit.

Date Status Determined: \* \_\_\_\_\_

<b>Youth Eligible for RHY Services?:*</b>		 <b>If "Yes", answer this:</b>	<b>Runaway Youth?:*</b>	
<input type="checkbox"/> No	<input type="checkbox"/> Yes		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected
 <b>If "No" answer this:</b>		<b>Reason why services are not funded by BCP grant?:*</b>		
		<input type="checkbox"/> Out of age range <input type="checkbox"/> Ward of the State - Immediate Reunification <input type="checkbox"/> Ward of the Criminal Justice System - Immediate Reunification <input type="checkbox"/> Other		

**Step 5: Barriers/Special Needs:\*** Identify whether a client has each individual barrier or not

<b>Alcohol Abuse*</b> <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Data Not Collected	 <b>If "Yes", answer this:</b>	<b>Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Data Not Collected
<b>Chronic Health Condition*</b> <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Data Not Collected		<b>Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Data Not Collected
<b>Developmental Disability*</b> <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Data Not Collected	 <b>If "Yes", answer this:</b>	<b>Expected to substantially impair ability to live independently?:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Data Not Collected
<b>Drug Abuse*</b> <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Data Not Collected	 <b>If "Yes", answer this:</b>	<b>Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Data Not Collected
<b>Mental Health*</b> <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Data Not Collected	 <b>If "Yes", answer this:</b>	<b>Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Data Not Collected
<b>Physical Disability*</b> <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Data Not Collected	 <b>If "Yes", answer this:</b>	<b>Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Refused <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Data Not Collected