

# RHY Supplemental Assessment Form

## Participating Agency Information

[Agency Name]  
 [Address]  
 [City, state zip]  
 [Phone]



making homelessness history

Emergency Fund Chicago Alliance The Learning Center

Month / Day / Year

HMIS Client ID#

**\*Street Outreach Providers answer only fields labeled "SOP" and follow subsequent questions as directed. All other programs are to answer every question of the assessment.**

		Client does not know	Client refused to provide	Data Not Collected
Sexual Orientation <b>SOP</b>	<input type="checkbox"/> Heterosexual <input type="checkbox"/> Lesbian <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Gay <input type="checkbox"/> Bisexual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Last Grade Completed (HUD)	<input type="checkbox"/> Less Than Grade 5 <input type="checkbox"/> Grade 12/ High School Diploma <input type="checkbox"/> Grades 5-6 <input type="checkbox"/> School Program Does not Have Grades <input type="checkbox"/> Grades 6-7 <input type="checkbox"/> GED <input type="checkbox"/> Grades 7-8 <input type="checkbox"/> Some College <input type="checkbox"/> Grades 9-11 <input type="checkbox"/> Associates Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Graduate Degree <input type="checkbox"/> Vocational Certification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School Status (HUD)	<input type="checkbox"/> Attending School Regularly <input type="checkbox"/> Graduated High School <input type="checkbox"/> Attending School Irregularly <input type="checkbox"/> Obtained GED <input type="checkbox"/> Dropped Out <input type="checkbox"/> Suspended <input type="checkbox"/> Expelled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>If Yes, Type of Employment?</i>	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal/ Sporadic (Including Day Labor)			<input type="checkbox"/>
<i>If No, Why not Employed?</i>	<input type="checkbox"/> Looking for work <input type="checkbox"/> Unable to work <input type="checkbox"/> Not looking for work			<input type="checkbox"/>
General Health Status	<input type="checkbox"/> Excellent <input type="checkbox"/> Fair <input type="checkbox"/> Very Good <input type="checkbox"/> Poor <input type="checkbox"/> Good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental Health Status	<input type="checkbox"/> Excellent <input type="checkbox"/> Fair <input type="checkbox"/> Very Good <input type="checkbox"/> Poor <input type="checkbox"/> Good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Status	<input type="checkbox"/> Excellent <input type="checkbox"/> Fair <input type="checkbox"/> Very Good <input type="checkbox"/> Poor <input type="checkbox"/> Good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant? <b>SOP</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>If Yes, Projected Birth Date</i>	<input type="text"/> / <input type="text"/> / <input type="text"/>			
Formerly a Ward of Child Welfare/ Foster Care Agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>If Yes, Number of Years?</i>	<input type="checkbox"/> Less than One Year <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 3 to 5 years			<input type="checkbox"/>
<i>If Less than one year, Number of months?</i>	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11			
<b>Young Person's Critical Issues</b>				
Household Dynamics	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/>
Sexual Orientation/Gender Identity-Youth	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/>

			Client does not know	Client refused to provide	Data Not Collected
Sexual Orientation/Gender Identity- Family	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/>
Housing Issues- Youth	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/>
Housing Issues- Family	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/>
School or Educational Issues- Youth	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/>
School or Educational Issues- Family Member	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/>
Unemployment- Youth	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/>
Unemployment- Family Member	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/>
Mental Health Issues- Youth	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/>
Mental Health Issues- Family Member	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/>
Health Issues- Youth	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/>
Health Issues- Family Member	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/>
Physical Disability- Youth	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/>
Physical Disability- Family Member	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/>
Mental Disability- Youth	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/>
Mental Disability- Family Member	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/>
Abuse and Neglect- Youth	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/>
Abuse and Neglect- Family Member	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/>
Alcohol or Other Drug Abuse- Youth	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/>
Alcohol or Other Drug Abuse- Family Member	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/>
Insufficient Income to Support Youth	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/>
Active Military Parent- Family Member	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/>
Incarcerated Parent of Youth	<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/>
If Yes for Incarcerated Parent, Please Specify	<input type="checkbox"/> One Parent/ Legal Guardian is incarcerated <input type="checkbox"/> Both Parents/ Legal Guardians are incarcerated <input type="checkbox"/> The only parent/ Legal Guardian is incarcerated				<input type="checkbox"/>

		Client does not know	Client refused to provide	Data Not Collected
Ever Received anything in exchange for sex (e.g. money, food, drugs, shelter)? <b>SOP</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, has this occurred in the past three months?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, How many times?</i>	<input type="checkbox"/> 1-3 <input type="checkbox"/> 8-11 <input type="checkbox"/> 4-7 <input type="checkbox"/> 12 or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, ever made/persuaded to have sex in exchange for something?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, to "ever made/persuaded to have sex in exchange for something", has this occurred in the last three months?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever afraid to quit/leave work due to threats of violence to yourself, family or friends? <b>SOP</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever promised work where work or payment was different than you expected? <b>SOP</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, for either "Workplace violence threats" or "Workplace promise difference," did you feel forced, pressured or tricked into continuing the job?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, for either "Workplace violence threats" or "Workplace promise difference," has this occurred in the last three months?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Referral Source

Individual	Temporary Shelter	Residential Project	Other
<input type="checkbox"/> Self- Referral <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Relative or Friend <input type="checkbox"/> Other Adult or Youth <input type="checkbox"/> Partner/Spouse <input type="checkbox"/> Foster Parent	<input type="checkbox"/> FYSB Basic Center Project <input type="checkbox"/> Other Youth Only Emergency Shelter <input type="checkbox"/> Emergency Shelter for Families <input type="checkbox"/> Emergency Shelter for Individuals <input type="checkbox"/> Domestic Violence Shelter <input type="checkbox"/> Safe Place <input type="checkbox"/> Other	<input type="checkbox"/> FYSB Transitional Living Project <input type="checkbox"/> Other Transitional Living Project <input type="checkbox"/> Group Home <input type="checkbox"/> Independent Living Project <input type="checkbox"/> Job Corps <input type="checkbox"/> Drug Treatment Center <input type="checkbox"/> Treatment Center <input type="checkbox"/> Educational Institute <input type="checkbox"/> Other Agency Project <input type="checkbox"/> Other Project	<input type="checkbox"/> Child Welfare/CPS <input type="checkbox"/> Non-Residential Independent Living Project <input type="checkbox"/> Other Project Operated by Your Agency <input type="checkbox"/> Other Youth Services Agency <input type="checkbox"/> Juvenile Justice <input type="checkbox"/> Law Enforcement/Police <input type="checkbox"/> School <input type="checkbox"/> Religious Organization <input type="checkbox"/> Mental Hospital <input type="checkbox"/> Other Organization

**Hotline:**  National Runaway Switchboard  
 Other Hotline

**Outreach Project :**  
 FYSB     Other

*If FYSB selected, how many times were you approached by outreach prior to entering the project?*   

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Client does not know</b>	<b>Client refused to provide</b>	<b>Data Not Collected</b>

***All Applicants Must Sign Below***

*By signing below I attest that the information I have provided for eligibility and intake is a true and accurate account of the current situation, income and household.*

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agency Representative Name (print): \_\_\_\_\_

Agency Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_