



FOR RUNAWAY AND HOMELESS YOUTH

RHYMIS/HMIS Intake Form

First Name _____ Middle _____ Last Name _____ *Suffix _____ (Jr/Sr.)

*Social Security No: _____ *Intake Date: _____

*Case Manager: _____ *Agency/Program: _____

*Case Manager Phone: _____ Case Manager Email: _____

Authorization to Share Protected Personal Information

I give authorization for my basic and personal information (including, but not limited to, name, gender, birth date, ethnicity, marital status, household configuration, military status, primary language spoken, and non-confidential services requested and received) to be shared with the organizations under which CCYCS operates and authorized staff of partner agencies in order to assist me in gaining access to services that I may need including housing, employment, financial assistance, vocational services, counseling and medical/mental health treatment. I understand that as I receive services, information will be collected about me and entered into the Runaway and Homeless Youth Management Information System (RHYMIS) and Homeless Management Information System (HMIS). My name and other identifying information in the RHYMIS/HMIS will not be shared with any agency not participating in the system (unless required to do so by law). **I understand that the current list of participating Partner Agencies may change over time to include other agencies that provide housing or services to the homeless population, and I give authorization for my information to be shared with any new Partner Agency.**

I understand that this consent expires 10 years after the signed date and authorizing my information to be entered into the RHYMIS/HMIS is voluntary. Refusing to do so will not limit my access to shelter or other services. I understand that I have the right to receive a copy of my RHYMIS/HMIS information upon written request. I understand that I may cancel this authorization at any time by written request to the County Homeless Program at 1350 Arnold Dr. Suite 202, Martinez, CA 94553, but that the cancellation will not be retroactive and all information lawfully collected will remain in HMIS.

Print Name of Participant _____ Signature of Participant _____ Date _____

Check here if interpreter used Interpreter: _____ Language: _____

Note: All information requested below is voluntary, however some questions may be required by specific programs to determine eligibility.

*1. Birth Date: _____ Age: _____ Full Approximate/Partial Client doesn't know Client refused

*2. Gender: Male Transgender Client doesn't know A gender other than singularly female or male (non-binary, genderfluid, agender, culturally specific gender)
 Female Questioning Client refused

*3. Sexual orientation: Straight/Heterosexual Gay Lesbian Bisexual Questioning/Unsure Client refused
 Other: _____

*4. What race best describes you? (Check all that apply) [HUD recommendation: Those of Latin heritage should mark American Indian if their ancestry from North, South or Central America. Those from the Far East (including India) should mark Asian. Those from the Middle East should mark White.]

White Black, African-American, or African Native Hawaiian or Pacific Islander Client doesn't Know
 Asian or Asian American American Indian/Alaskan Native/Indigenous Client Refused

*5. Ethnicity: Hispanic/Latin(a)(o)(x) Non-Hispanic/Non-Latin(a)(o)(x) Client doesn't know Client refused

*6. Have you ever served in the US Military? Yes No Client doesn't know Client refused

Year entered military service: _____ Year separated from military service: _____

Branch of the Military? Army Navy Air Force Marines Coast Guard

Theater of Operations (Circle Yes or No for each)

World War II	Y / N	Afghanistan	Y / N
Korean War	Y / N	Iraqi Freedom	Y / N
Vietnam War	Y / N	Iraq New Dawn	Y / N
Persian Gulf War	Y / N	Other	Y / N

Discharge status (Check one)

Honorable Dishonorable
 General under honorable conditions Uncharacterized/Other
 Under other than honorable conditions (OTH) Client doesn't know
 Bad conduct Client refused

7. What is your primary language?

English Spanish Chinese Vietnamese Tagalog Arabic Other

8. Phone: _____

9. Email: _____

10. Identification: _____

11. What is your current or most recent mailing address? Currently staying there? Yes / No

Address: _____ City _____ State _____ Zip _____

***12. Relationship to head of household:**

- Self Child Spouse/Partner Other relation Other: Non-relation member

13. Who referred you to this program?

- | | | |
|---|--|--|
| <input type="checkbox"/> 211 Crisis line | <input type="checkbox"/> CARE/Drop in center | <input type="checkbox"/> Self |
| <input type="checkbox"/> Other Crisis line | <input type="checkbox"/> Benefits worker/Case manager | <input type="checkbox"/> Friends/Relatives |
| <input type="checkbox"/> Shelter Hotline | <input type="checkbox"/> VA | <input type="checkbox"/> Web/Internet |
| <input type="checkbox"/> Mental Health Access line | <input type="checkbox"/> CORE outreach | <input type="checkbox"/> Church/Religious organization |
| <input type="checkbox"/> Hospital (Non-psychiatric) | <input type="checkbox"/> Police /Law Enforcement | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Clinic/Outpatient facility | <input type="checkbox"/> Criminal justice system (Non AB109) | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Skilled nursing facility | <input type="checkbox"/> AB109 Probation officer | <input type="checkbox"/> Client refused to answer |
| <input type="checkbox"/> Residential program | | |

14. RHY Referral Source (*For Pomona/Mary McGovern/NCFC Only, choose one):

- | | | |
|---|--|--|
| <input type="checkbox"/> Self-Referral | <input type="checkbox"/> Hotline | <input type="checkbox"/> School |
| <input type="checkbox"/> Individual: Parent/Guardian/Relative/Friend/Foster Parent/Other Individual | <input type="checkbox"/> Child Welfare/CPS | <input type="checkbox"/> Other Organization |
| <input type="checkbox"/> Outreach Project | <input type="checkbox"/> Juvenile Justice | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Temporary Shelter | <input type="checkbox"/> Law Enforcement | <input type="checkbox"/> Client refused |
| <input type="checkbox"/> Residential Project | <input type="checkbox"/> Mental Hospital | |

***Living Situation**

***15. What best describes your living situation last night (prior to entering this program) [Please choose one of the three following situations and only answer the questions within that column]:**

<input type="checkbox"/> Literally homeless	<input type="checkbox"/> Institutional situation	<input type="checkbox"/> Transitional & Permanent housing
<input type="checkbox"/> Place not meant for habitation (vehicle, abandoned bldg, train station/airport, or anywhere outside) <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded host home shelter <input type="checkbox"/> Safe haven <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected	<input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail, prison, or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center	<input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Host home (non-crisis) <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Permanent housing for formerly homeless persons (other than RRH) <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Rental by client, with GPD TIP housing subsidy <input type="checkbox"/> Rental by client, with RRH or equivalent subsidy <input type="checkbox"/> Rental by client with Housing Choice Voucher (HCV) (tenant or project based) <input type="checkbox"/> Rental by client in a public housing unit <input type="checkbox"/> Rental by client with other ongoing subsidy <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> Staying or living in a friend's room, apartment or house
*Length of living situation prior to entering this program: <input type="checkbox"/> 1 night or less <input type="checkbox"/> 2 nights to 6 nights <input type="checkbox"/> 1 week or more, but less than 1 month <input type="checkbox"/> 1 month or more, but less than 90 days <input type="checkbox"/> 90 Days or more, but less than 1 year <input type="checkbox"/> 1 year or longer <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	*Length of living situation prior to entering this program: <input type="checkbox"/> 1 night or less <input type="checkbox"/> 2 nights to 6 nights <input type="checkbox"/> 1 week or more, but less than 1 month <input type="checkbox"/> 1 month or more, but less than 90 days <input type="checkbox"/> 90 Days or more, but less than 1 year <input type="checkbox"/> 1 year or longer <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	*Length of living situation prior to entering this program: <input type="checkbox"/> 1 night or less <input type="checkbox"/> 2 nights to 6 nights <input type="checkbox"/> 1 week or more, but less than 1 month <input type="checkbox"/> 1 month or more, but less than 90 days <input type="checkbox"/> 90 Days or more, but less than 1 year <input type="checkbox"/> One year or longer <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
*Approximate date this episode of homelessness started: ____ / ____ / ____	*If the length of stay above was less than 90 days, did you enter the institution from the streets, Emergency shelter, or Safe Haven? <input type="checkbox"/> Yes <input type="checkbox"/> No *If yes, approximate date this episode of homelessness started: ____ / ____ / ____ Note: If homelessness began prior to institution stay, and the institution stay was less than 90 days, the stay also counts as time homeless.	*If the length of stay above was less than 7 nights, did you enter the above housing situation from the streets, Emergency shelter, or Safe Haven? <input type="checkbox"/> Yes <input type="checkbox"/> No * If yes, approximate date this episode of homelessness started: ____ / ____ / ____ Note: If client stayed in a housed situation for less than 7 days, the stay also counts as time homeless.

*** For emergency shelters and street outreach only:**

***16.** If client is coming from an institution where they stayed more than 90 days or a housed situation where they stayed MORE than 7 days, then their start date of homelessness would be today's date (Intake Date): **Intake Date:** ____ / ____ / ____

***17. If homeless, number of times you have been homeless on the streets/shelter in the past three years including today.**

- | | | |
|----------------------------------|--|--|
| <input type="checkbox"/> 1 time | <input type="checkbox"/> 3 times | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> 2 times | <input type="checkbox"/> 4 or more times | <input type="checkbox"/> Client refused |

***18. If homeless, total number of months homeless in the past three years** [Note: Any single day or part of a month spent homeless should be counted as 1 month. Add up these episodes for a cumulative total.]: _____ months

***19. Housing status at program entry**

- Category 1 – Literally Homeless (i.e. streets, shelter, transitional housing)
- Category 2 – At imminent risk of losing housing (within 14 days)
- Category 3 – Unaccompanied youth (under 25) or families with minors who are not literally homeless but are homeless under Dept. of Education Definition—they may be in a motel, couch-surfing, doubled-up
- Category 4 – Fleeing domestic violence and has no other residence or resources to obtain permanent housing
- At risk of homelessness—not literally homeless but is low income and either: doubled-up, couch-surfing or living in motel; will lose housing within 21 days; is exiting a publicly funded institution; or has moved twice in the past 60 days.
- Stably housed

***20. City where you lost stable housing (does not include shelter, transitional housing, or institutions). For prevention programs, city where you are at-risk of losing your housing?**

- | | | | | | |
|--|-----------------------------------|--|-------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Alamo | <input type="checkbox"/> Byron | <input type="checkbox"/> Danville | <input type="checkbox"/> Kensington | <input type="checkbox"/> Oakley | <input type="checkbox"/> Port Costa |
| <input type="checkbox"/> Antioch | <input type="checkbox"/> Canyon | <input type="checkbox"/> Discovery Bay | <input type="checkbox"/> Knightsen | <input type="checkbox"/> Orinda | <input type="checkbox"/> Richmond |
| <input type="checkbox"/> Bay Point | <input type="checkbox"/> Clayton | <input type="checkbox"/> El Cerrito | <input type="checkbox"/> Lafayette | <input type="checkbox"/> Pacheco | <input type="checkbox"/> Rodeo |
| <input type="checkbox"/> Bethel Island | <input type="checkbox"/> Clyde | <input type="checkbox"/> El Sobrante | <input type="checkbox"/> Martinez | <input type="checkbox"/> Pinole | <input type="checkbox"/> San Pablo |
| <input type="checkbox"/> Blackhawk | <input type="checkbox"/> Concord | <input type="checkbox"/> Hercules | <input type="checkbox"/> Moraga | <input type="checkbox"/> Pittsburg | <input type="checkbox"/> San Ramon |
| <input type="checkbox"/> Brentwood | <input type="checkbox"/> Crockett | | <input type="checkbox"/> N Richmond | <input type="checkbox"/> Pleasant Hill | <input type="checkbox"/> Walnut Creek |

Other Bay Area county:

- | | | | |
|--------------------------------------|--|---|--|
| <input type="checkbox"/> Alameda | <input type="checkbox"/> Marin | <input type="checkbox"/> Monterey | <input type="checkbox"/> Other part of Contra Costa County _____ |
| <input type="checkbox"/> Napa | <input type="checkbox"/> San Francisco | <input type="checkbox"/> San Mateo | <input type="checkbox"/> Other county not listed here _____ |
| <input type="checkbox"/> Santa Clara | <input type="checkbox"/> Santa Cruz | <input type="checkbox"/> Client refused | |
| <input type="checkbox"/> Sonoma | <input type="checkbox"/> Solano | | |

***21. In which city did you sleep last night? (this means: where did you sleep prior to entering this program)**

City _____ State _____

***22. If homeless, is this your first time experiencing homelessness (being without housing)?** Yes / No

***23. Total length of time client has been homeless (without housing) [short breaks are acceptable].** ____ Years ____ Months

***Health and Disability**

***24. Please Circle Yes or No for each of the following disability types:**

Physical	Y / N	Long Term and Impairs Independence?	Y / N	Mental health problem	Y / N	Long Term and Impairs Independence?	Y / N
Developmental	Y / N			Alcohol abuse	Y / N	Long Term and Impairs Independence?	Y / N
Chronic health condition	Y / N	Long Term and Impairs Independence?	Y / N	Drug abuse	Y / N	Long Term and Impairs Independence?	Y / N
HIV/AIDS	Y / N			Both Alcohol and Drug Abuse	Y / N	Long Term and Impairs Independence?	Y / N

Note: Chronic health condition – a diagnosed condition that is more than three months in duration and is either not curable or has residual effects that limit daily living and require adaptation in function or special assistance. Examples include but are not limited to: heart disease, severe asthma, diabetes, arthritis-related conditions, adult onset cognitive impairments (including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive related conditions), severe headache/migraine, cancer, chronic bronchitis, liver condition, stroke, or emphysema.

Do you have a disabling condition? (If any of the above conditions are Long Term and Impairs Independence, or if "Y" to Developmental or HIV/AIDS)

- Yes No Client doesn't know Client refused

***25. Well-Being - Use the scale provided below. You may also use Client doesn't know (DK) or Client refused(R)**

Strongly disagree (0), Somewhat disagree (1), Neither agree or disagree (2) Somewhat agree (3), Strongly agree (4),	Client perceives their life has value and worth _____ Client perceives they have support from others who will listen to problems _____ Client perceives they have a tendency to bounce back after hard times _____
Not at all (0) , Once a month (1) , Several times a month (2), Several times a week (3), At least every day (4)	Client's frequency of feeling nervous, tense, worried, frustrated, or afraid _____

***26. Are you currently covered by health insurance** Yes____ No____ Client doesn't know ____ Client refused ____

Please answer Yes or No for each of the following health insurance types:

Health Insurance	Currently covered?	*HOPWA Only: If no, reason?	Health Insurance	Currently covered?	*HOPWA Only: If no, reason?
Medicaid/Medi-Cal	Y / N		Health insurance obtained through COBRA	Y / N	
Medicare	Y / N		Private pay health Insurance	Y / N	
State Children's Health Ins Program (SCHIP)	Y / N		State health insurance for adults	Y / N	
Employer-Provided Health Insurance	Y / N		Indian health services program	Y / N	
Veteran's Administration (VA) Medical Services	Y / N		Other	Y / N	

***HOPWA only:** If not covered, indicate reason: (A= Applied but decision pending, B = Applied but client was ineligible, C = Client did not apply, D = Insurance Type not applicable.)

	Excellent	Very Good	Good	Fair	Poor		
*27. What is your General Health Status?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Client doesn't know	Client refused
*28. What is your Dental Health Status?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Client doesn't know	Client refused
*29. What is your Mental Health Status?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Client doesn't know	Client refused

30. Medications you are taking, if any:
 31. Do you currently use any substances? Yes / No
 Alcohol Tobacco Crack Heroin (Methadone) Speed/crank Marijuana Other

***Income and Employment**

*32. Are you employed? Yes No
 If employed, type of employment? Full Time Part Time Seasonal/Sporadic (including day labor)
 Hours Worked Last Week _____ Where? _____
 If not employed, why? Looking for work Unable to work Not looking for work

*33. Any income received from any source in the last 30 days? Yes / No (Also answer Yes or No to each of the following):

Source	Rec in past 30 days?	Monthly amount	Source	Rec in past 30 days?	Monthly amount
Earned income (ie. employment income)	Y / N		VA non-service connected disability pension	Y / N	
Unemployment insurance	Y / N		Pension from a former job (including military retirement pay)	Y / N	
Workers compensation	Y / N		Temporary assistance for needy families (TANF)	Y / N	
Private disability insurance	Y / N		General assistance (GA)	Y / N	
VA service-connected disability compensation	Y / N		Alimony or Other spousal support	Y / N	
SSDI	Y / N		Child support	Y / N	
SSI	Y / N		Other: Cash Income	Y / N	
Retirement income from Social Security	Y / N				

*34. Any non-cash benefits received in the last 30 days? Yes / No (Also answer yes or no to each of the following):

Source	Received in past 30 days?	Source	Received in past 30 days?
Supplemental nutrition assistance program (SNAP/Food Stamps)	Y / N	TANF Transportation Services	Y / N
Special Supplemental Nutrition Pgm for Women, Infants, & Children (WIC)	Y / N	Other TANF-Funded Services	Y / N
TANF Childcare services	Y / N	Other Non-Cash Benefit	Y / N

***Education**

*35. School Status
 Attending school regularly Graduated from high school Dropped out Client doesn't know
 Attending school irregularly Obtained GED Suspended Client refused
 Expelled

*36. Last grade completed?
 < 5th grade 9th – 11th Grade School program does not have grade levels Graduate degree
 Grade 5-6 12th Grade Some college Vocational certification
 Grade 7-8 GED Associates degree Client doesn't know
 Bachelor's degree Client refused

Criminal history

37. Have you ever been convicted of a crime (Y/N)? ____ Explain crime: _____
 If yes, were you convicted within the last 6 months (Y/N)? ____

38. Are you currently on probation (Y/N)? ____ Probation office's name and phone no.: _____
 Probation end date (mm/dd/yy): __/__/__

39. Are you currently on parole (Y/N)? ____ Parole office's name and phone no.: _____
 Parole end date (mm/dd/yy): __/__/__

40. Have you ever been incarcerated in State/County/Federal Prison (Y/N)? ____ If Yes:
 a) Were you released as a result of California Assembly Bill (AB) 109? (circle one) Yes / No
 b) Were you released within the last 6 months? (circle one) Yes / No

Youth Related Questions

Labor Exploitation

41. Have you ever been afraid to leave or quit a work situation due to fears of violence or other threats of harm to yourself, family or friends?

- Yes No Client doesn't Know Client refused

42. Have you ever been promised work where the work or payment ended up being different than what you expected?

- Yes No Client doesn't know Client refused

43. If yes to Question 41, did you feel forced, pressured, or tricked into continuing this job?

- Yes No Client doesn't know Client refused

44. If yes to Question 41, have you had any jobs like these in the last 3 months?

- Yes No Client doesn't know Client refused

Sexual Exploitation

45. a) Have you ever received anything in exchange for having sexual relations with another person, such as money, food, drugs, or shelter?

- Yes No Doesn't know Refused

b) Has it been in the past 3 months?

- Yes No Doesn't know Refused

c) How many times?

- 1-3 12 or more
 4-7 Client doesn't know
 8-11 Client refused

46. a) If yes to Question 45, did someone ever make you or persuade you to have sex with anyone else in exchange for something, such as money, food, drugs or shelter?

- Yes No Client doesn't know Client refused

b) Has it been in the past 3 months?

- Yes No Doesn't know Refused

*47. Have you ever been a victim of domestic violence/abuse?

- Yes No Client doesn't know Client refused

If Yes, please indicate when the most recent domestic violence experience occurred:

- Within the past 3 months 3-6 months ago 6-12 months ago More than a year ago

*48. Are you currently fleeing domestic violence?

- Yes No Doesn't know Client refused

49. Are you pregnant?

- Yes, due date _____ No Doesn't know Refused

50. Do you have any children?

- Yes, How Many? _____ No

51. Do you have custody?

- Yes No

52. Please list information about all dependent children (under 18 years old) in your household (Name, SSN, DOB, Gender, Race, Ethnicity, Disabilities)

*53. Are you currently a ward of Child Welfare/Foster Care? Yes No

*54. Have you ever been a ward of Child Welfare/Foster Care? Yes No

If yes, number of years: Less than 1 year 1 – 2 years 3 – 5 or more years

*55. Are you currently involved in the juvenile justice system? Yes No

*54. Have you ever been a ward of the juvenile justice system? Yes No

If yes, number of years: Less than 1 year 1 – 2 years 3 – 5 or more years

57. Family Critical Issues. Please mark the critical issues being experienced by youth or a family member

- | | |
|--|---|
| Unemployment <input type="checkbox"/> Yes <input type="checkbox"/> No | Alcohol or other Drug Abuse – Family Member <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mental Health Issues <input type="checkbox"/> Yes <input type="checkbox"/> No | Insufficient Income to Support Youth – Family Member <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Physical Disability – Family Member <input type="checkbox"/> Yes <input type="checkbox"/> No | Incarcerated Parent of Youth <input type="checkbox"/> Yes <input type="checkbox"/> No |

For TLP Case Manager Use Only

58. Is client eligible for AB12/DJJ funding or services? Yes No

59. Funding Source: THP+ THP+FC Probation: court-ordered Probation: DJJ aftercare Other: _____

Thank you for taking the time to tell me a little about yourself. Again, this information will be shared only with other CCYCS staff and collaborative agencies that are involved with your case. You will now be referred to a case manager who can further assist you with short and long-term goals.