COHMIS

RHY Assessment Form

CLIENT NAME			
Last:			
First:			
Middle:		Suffix	

PROJECT NAME	
ASSESSMENT DATE (MM/DD/YYYY)	
ASSESSMENT TYPE	☐ Annual Assessment ☐ Status Update

If client has become Engaged by project (Street Outreach Projects Only)	
DATE OF ENGAGEMENT *(enter on Enrollment Screen for All Clients)*	MONTH DAY YEAR

RHY-BCP STATUS (BCP-Prevention & BCP-Emergency Shelter Only)	
DATE OF STATUS DETERMINATION	MONTH DAY YEAR
FYSB YOUTH ELIGIBLE FOR RHY SERVICES	☐ No* ☐ Yes*

***If NO for FYSB YOUTH – Reason services are not funded by BCP grant**

☐ Ward of the State-Immediate Reunification
☐ Ward of the criminal justice system-immediate reunification
☐ Out of age range
☐ Other _____

***If YES for FYSB YOUTH – Runaway Youth?**

☐ No
☐ Yes
☐ Client doesn't know
☐ Client refused
☐ Data not collected

DISABLING CONDITION

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

PHYSICAL DISABILITY

☐ No
☐ Yes*

☐ Client doesn't know
☐ Client refused
☐ Data not collected

***If YES for Physical Disability**
Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

DEVELOPMENTAL DISABILITY

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

CHRONIC HEALTH CONDITION

☐ No
☐ Yes*

☐ Client doesn't know
☐ Client refused
☐ Data not collected

***If YES for Chronic Health Condition**
Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

HIV/AIDS

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

MENTAL HEALTH PROBLEM

☐ No
☐ Yes*

☐ Client doesn't know
☐ Client refused
☐ Data not collected

***If YES for Mental Health Problem**
Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

SUBSTANCE ABUSE PROBLEM

☐ No
☐ Alcohol abuse
☐ Drug abuse
☐ Both alcohol and drug abuse

☐ Client doesn't know
☐ Client refused
☐ Data not collected

***If YES for Substance Abuse Problem**
Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

CASH INCOME FOR INDIVIDUAL		
Income from Any Source?	☐ No ☐ Yes*	☐ Client doesn't know ☐ Client refused ☐ Data not collected

***If YES to Income from Any Source – Indicate all sources that apply**

Income Source (Check all that apply)	Monthly Amount
☐ Earned Income	
☐ Unemployment Insurance	
☐ Supplemental Security Income (SSI)	
☐ Social Security Disability Insurance (SSDI)	
☐ VA Service-Connected Disability Compensation	
☐ VA Non-Service Connected Disability Compensation	
☐ Private Disability Insurance	
☐ Worker's Compensation	
☐ Temporary Assistance for Needy Families (TANF)	
☐ General Assistance (GA)	
☐ Retirement Income from Social Security	
☐ Pension or Retirement Income from a Former Job	
☐ Child Support	
☐ Alimony and Other Spousal Support	
☐ Other Cash Income (Specify: _____)	
Total Monthly Amount	

NON-CASH BENEFITS		
Receiving Non-Cash Benefits?	☐ No ☐ Yes*	☐ Client doesn't know ☐ Client refused ☐ Data not collected

***If YES to Receiving Non-Cash Benefits – Indicate all sources that apply**

☐ Supplemental Nutrition Assistance Program (SNAP)
☐ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
☐ TANF Childcare Services
☐ TANF Transportation Services
☐ Other TANF-Funded Services
☐ Other Non-Cash Benefit (Specify source:_____)

HEALTH INSURANCE		
Covered by Health Insurance?	☐ No ☐ Yes*	☐ Client doesn't know ☐ Client refused ☐ Data not collected

***If YES to Covered by Health Insurance – Indicate all sources that apply**

☐ Medicaid	☐ Health Insurance Obtained Through COBRA
☐ Medicare	☐ Private Pay Health Insurance
☐ State Children's Health Insurance Program	☐ State Health Insurance for Adults
☐ Veteran's Administration (VA) Medical Services	☐ Indian Health Services Program
☐ Employer-Provided Health Insurance	☐ Other Health Insurance (Specify source:_____)

PREGNANCY STATUS		
☐ No ☐ Yes*	☐ Client doesn't know ☐ Client refused ☐ Data not collected	
***If YES for Pregnancy Status, Due Date:**	MONTH	DAY YEAR

CONTACT INFORMATION (Optional – entered on the **Contacts** tab)	
Phone number	
Email	

ADDRESS (Optional – entered on the **Locations** tab)			
Street			
City			
State		Zip Code	

Signature of applicant stating all information is true and correct

Date