

# HMIS Intake and Enrollment Form RHY

Client ID: \_\_\_\_\_

**Program Start Date:** \_\_\_\_\_

Staff Completing HMIS form \_\_\_\_\_

**Identification** - All fields required unless otherwise noted

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Last Name \_\_\_\_\_ Suffix \_\_\_\_\_

Name Data Quality: Did the client provide their full name?	Social Security Number (SSN)	Birth Date (DOB)
<input type="checkbox"/> Full Name Reported <input type="checkbox"/> Partial, street name, or code name reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	_____ - _____ - _____ <input type="checkbox"/> Full SSN reported <input type="checkbox"/> Approximate or partial SSN reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	_____ / _____ / _____ <input type="checkbox"/> Approximate or partial DOB reported <input type="checkbox"/> Full DOB reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

**Basic Demographics – All fields required unless otherwise noted**

Race (Check all that apply)	Ethnicity
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/ Non-Latino <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Gender	Pregnancy Status
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans Male (Female to Male) <input type="checkbox"/> Trans Female (Male to Female) <input type="checkbox"/> Non-Conforming (Not exclusively male or Female) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes* (Due Date _____) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Veteran (Have you ever served in the U.S. Military?) 18 and over
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Relationship to Head of Household	Project Start Date
<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Dependent Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other Family Member <input type="checkbox"/> Other Non-Family <input type="checkbox"/> Self	_____ / _____ / _____

Disabling Condition
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

**\*\*Data Assessment for Living Situation: (FOR ALL PERSONS ENTERING EMERGENCY SHELTER, SAFE HAVEN, AND STREET OUTREACH) BCP ONLY go to page 2**

**\*\*Data Assessment for Living Situation: (FOR ALL PERSONS ENTERING ALL OTHER PROJECTS EXCEPT EMERGENCY SHELTER, SAFE HAVEN, AND STREET OUTREACH) BCPHP and TLP go to page 3**

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Staff Completing HMIS form \_\_\_\_\_

Universal Data Assessment		
Client Location: CA-510 – Turlock/ Modesto/ Stanislaus County CoC		
Living Situation: BCP Only(FOR ALL PERSONS ENTERING EMERGENCY SHELTER, SAFE HAVEN, AND STREET OUTREACH)		
Question	Check One Answer	
1. What was the situation you were living in immediately prior to project entry? (The night before) (Type of residence)	<input type="checkbox"/> Place not meant for habitation <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter <input type="checkbox"/> Safe Haven <input type="checkbox"/> Interim Housing <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"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Permanent housing (Other than RRH) for formerly homeless persons <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with VASH subsidy <input type="checkbox"/> Rental by client, with GPD TIP subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy (Including RRH) <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 <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	
2. How long was the client staying in that place? (Length of stay in prior living situation)	<input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> One month or more, but less than 90 days	<input type="checkbox"/> 90 days or more, but less than one year <input type="checkbox"/> One year or longer <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused
3. What approximate date did you start living on the streets, emergency shelter, or safe haven? (Approximate date homelessness started)	_____ / _____ / _____	
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"/> Two Times <input type="checkbox"/> Three Times	<input type="checkbox"/> Four or more times <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Total Number of months homeless on the streets, in ES, or SH in the past three years	<input type="checkbox"/> One Month (this time is the first month) <input type="checkbox"/> 2-12 (____ months)	<input type="checkbox"/> More than 12 <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

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Universal Data Assessment		
<p><b>Living Situation: BCPHP and TLP (FOR ALL PROJECTS EXCEPT EMERGENCY SHELTER, SAFE HAVEN, AND STREET OUTREACH)</b></p>		
<p><b>1. What was type of residence you were living in immediately prior to project entry? (The night before)</b> <b>Literally Homeless Situations</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Place not meant for habitation</li> <li><input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter</li> <li><input type="checkbox"/> Safe Haven</li> <li><input type="checkbox"/> Interim Housing</li> </ul>	<p><b>2. Length of stay in prior living situation?</b> <b>For literally homeless situations:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> One night or less</li> <li><input type="checkbox"/> Two to six nights</li> <li><input type="checkbox"/> One week or more, but less than one month</li> <li><input type="checkbox"/> One month or more, but less than 90 days</li> <li><input type="checkbox"/> 90 days or more, but less than one year</li> <li><input type="checkbox"/> One year or longer</li> <li><input type="checkbox"/> Client doesn't know</li> <li><input type="checkbox"/> Client refused</li> </ul>	<p><b>3. Did the Client stay less than... Not Applicable (Continue to questions 5-7)</b></p>
<p><b>1. What was the living Situation you were living in immediately prior to project entry?</b> <b>Institutional Situations</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Foster care home or foster care group home</li> <li><input type="checkbox"/> Hospital or other residential non-psychiatric medical facility</li> <li><input type="checkbox"/> Jail, prison or juvenile detention facility</li> <li><input type="checkbox"/> Long-term care facility or nursing home</li> <li><input type="checkbox"/> Psychiatric hospital or other psychiatric facility</li> <li><input type="checkbox"/> Substance abuse treatment facility or detox center</li> </ul>	<p><b>2. Did you stay less than... 90 Days</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes (Continue to questions 3-4)</li> <li><input type="checkbox"/> No (Enter Wellness Assessment)</li> </ul>	<p><b>3. Length of stay in prior living situation?</b> <b>For institutional situations:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> One night or less</li> <li><input type="checkbox"/> Two to six nights</li> <li><input type="checkbox"/> One week or more, but less than one month</li> <li><input type="checkbox"/> One month or more, but less than 90 days</li> <li><input type="checkbox"/> 90 days or more, but less than one year</li> <li><input type="checkbox"/> One year or longer</li> <li><input type="checkbox"/> Client doesn't know</li> <li><input type="checkbox"/> Client refused</li> </ul>
<p><b>1. What was the living Situation you were living in immediately prior to project entry?</b> <b>Transitional &amp; Permanent Housing Situations</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher</li> <li><input type="checkbox"/> Owned by client, no ongoing housing subsidy</li> <li><input type="checkbox"/> Owned by client, with ongoing housing subsidy</li> <li><input type="checkbox"/> Permanent housing (Other than RRH) for formerly homeless persons</li> <li><input type="checkbox"/> Rental by client, no ongoing housing subsidy</li> <li><input type="checkbox"/> Rental by client, with VASH subsidy</li> <li><input type="checkbox"/> Rental by client, with GPD TIP subsidy</li> <li><input type="checkbox"/> Rental by client, with other ongoing housing subsidy (Including RRH)</li> <li><input type="checkbox"/> Residential project or halfway house with no homeless criteria</li> <li><input type="checkbox"/> Staying or living in a family member's room, apartment or house</li> <li><input type="checkbox"/> Staying or living in a friend's room, apartment or house</li> <li><input type="checkbox"/> Transitional housing for homeless persons (including homeless youth)</li> </ul>	<p><b>2. Did you stay less than... 7 Nights</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes (Continue to questions 3-4)</li> <li><input type="checkbox"/> No (Answer 3 then continue to Wellness Assessment)</li> </ul>	<p><b>3. Length of stay in prior living situation?</b> <b>Transitional &amp; Permanent Housing Situations</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> One night or less</li> <li><input type="checkbox"/> Two to six nights</li> <li><input type="checkbox"/> One week or more, but less than one month</li> <li><input type="checkbox"/> One month or more, but less than 90 days</li> <li><input type="checkbox"/> 90 days or more, but less than one year</li> <li><input type="checkbox"/> One year or longer</li> <li><input type="checkbox"/> Client doesn't know</li> <li><input type="checkbox"/> Client refused</li> </ul>

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**Staff Completing HMIS form** \_\_\_\_\_

4. On the night before your current housing situation did you stay on the street, Emergency Shelter, or Safe Haven	<input type="checkbox"/> Yes(Continue to questions 5-7) <input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> No (Continue with Wellness Assessment) <input type="checkbox"/> Client Refused
5. What approximate date did you start living on the streets, emergency shelter, or safe haven? <i>(Approximate date homelessness started)</i> _____/_____/_____		
6. 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"/> Two Times <input type="checkbox"/> Three Times	<input type="checkbox"/> Four or more times <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
7. Total Number of months homeless on the streets, in ES, or SH in the past three years?	<input type="checkbox"/> One Month (this time is the first month) <input type="checkbox"/> 2-12 (____ months)	<input type="checkbox"/> More than 12 <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
<b>Wellness Assessment</b>		
<b>Health Insurance</b>		
<input type="checkbox"/> Yes <i>(Enter the Source)</i> <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused		
<b>Health Insurance Sources</b>		
<input type="checkbox"/> Private Pay Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> MEDICAID <input type="checkbox"/> State Children's Health Insurance (SCHIP) <input type="checkbox"/> VA Medical Services <input type="checkbox"/> Employer Provided Health Insurance	<input type="checkbox"/> Health Insurance obtained through COBRA <input type="checkbox"/> State Health Insurance Adults (Medi-Cal) <input type="checkbox"/> Indian Health Services Program  <input type="checkbox"/> Other: _____	
<b>BCP Status:</b>		
<b>Yes (select options below)</b>	<b>No (Reason why services are not funded by BCP Grant)</b>	
Date of Determination: _____  Youth eligible for RHY services? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is youth a runaway?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
<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		
<b>Barriers:</b>		
	<b>Barrier Present</b>	<b>Condition is Indefinite</b>
Alcohol Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
Chronic Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
Development Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
Mental health	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
Physical Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
<b>Domestic Violence</b>		
<b>Is the client a domestic violence victim/survivor?</b>	<input type="checkbox"/> Yes (Answer questions below) <input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
<b>If yes, How long ago did you have this experience?</b>	<input type="checkbox"/> Within the past 3 months <input type="checkbox"/> 3 months to 6 months ago <input type="checkbox"/> 6 months to one year <input type="checkbox"/> One year ago or more <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
<b>If yes, are you currently fleeing?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	

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Financial Assessment (Check all that Apply and Enter amount)			
Income Source (Check all that apply)	Stated Income (Monthly)	Non-Cash Resources (Check all that apply)	Stated Amounts (Monthly)
<input type="checkbox"/> Yes (Check all Sources that Apply) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused		<input type="checkbox"/> Yes (Check all Sources that Apply) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
<input type="checkbox"/> Earned Income ( <i>employment wages / cash</i> )	\$	<input type="checkbox"/> Special Supplemental nutritional Program Women and Children	\$
<input type="checkbox"/> Unemployment Insurance	\$	<input type="checkbox"/> Food Stamps (CalFresh) SNAP	\$
<input type="checkbox"/> Supplemental Security Income (SSI)	\$	<input type="checkbox"/> CalWorks Child Care/TANF Child Care Services	\$
<input type="checkbox"/> Social Security Disability Income (SSDI)	\$	<input type="checkbox"/> CalWorks Transportation (TANF)	\$
<input type="checkbox"/> Private Disability Insurance	\$	<input type="checkbox"/> Other CalWorks-Funded Services (TANF)	\$
<input type="checkbox"/> Workers Compensation	\$	<input type="checkbox"/> Other	\$
<input type="checkbox"/> VA Service-Connected Disability Compensation	\$		
<input type="checkbox"/> VA Non-Service-Connected Disability Pension	\$		
<input type="checkbox"/> Pension or Retirement income from a job	\$		
<input type="checkbox"/> TANF	\$		
<input type="checkbox"/> General Assistance	\$		
<input type="checkbox"/> Retirement (Social Security)	\$		
<input type="checkbox"/> Child Support	\$		
<input type="checkbox"/> Alimony or other Spousal Support	\$		
<input type="checkbox"/> Other Income	\$		
Employment Assessment			
<input type="checkbox"/> Yes (Complete Information Below)		<input type="checkbox"/> No(Complete Information Below)	
<input type="checkbox"/> Client Doesn't Know		<input type="checkbox"/> Client Refused	
<b>If Yes-Type of Employment</b>	<input type="checkbox"/> Full-time	<input type="checkbox"/> Part-Time	<input type="checkbox"/> Seasonal/Sporadic (including day labor)
<b>If No Why not employed?</b>	<input type="checkbox"/> Looking for work	<input type="checkbox"/> Unable to work	<input type="checkbox"/> Not Looking for work
Educational Assessment		Post-Secondary Options	
<b>Highest Grade Completed</b>	<input type="checkbox"/> No School Completed <input type="checkbox"/> School program does not have a grade level <input type="checkbox"/> Nursery School to 4 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> or 6 <sup>th</sup> grade <input type="checkbox"/> 7 <sup>th</sup> or 8 <sup>th</sup> grade <input type="checkbox"/> 9 <sup>th</sup> grade	<input type="checkbox"/> 10 <sup>th</sup> grade <input type="checkbox"/> 11 <sup>th</sup> grade <input type="checkbox"/> 12 <sup>th</sup> grade, No Diploma <input type="checkbox"/> High School Diploma <input type="checkbox"/> GED <input type="checkbox"/> Post-Secondary (Fill-in level) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Associates Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Master's Degree <input type="checkbox"/> Doctorate Degree <input type="checkbox"/> Other Graduate/Professional degree <input type="checkbox"/> Vocational certification/ Certificate of advanced training or skilled artisan

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<b>School Status</b>			
<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			
<b>Health Assessment</b>			
<b>General Health Status</b>			
<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
<b>Dental Health Status</b>			
<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
<b>Mental Health Status</b>			
<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
<b>Sexual Orientation</b>			
<input type="checkbox"/> Heterosexual	<input type="checkbox"/> Questioning/Unsure		
<input type="checkbox"/> Gay	<input type="checkbox"/> Client Doesn't Know		
<input type="checkbox"/> Lesbian	<input type="checkbox"/> Client Refused		
<input type="checkbox"/> Bi-sexual			
<b>RHY Entry Assessment</b>			
<b>Referral Resources</b>			
<input type="checkbox"/> Self-Referral	<input type="checkbox"/> Child Welfare/CPS		
<input type="checkbox"/> Individual/Parent/Guardian/Relative /Friend/Foster Parent/Other Individual	<input type="checkbox"/> Juvenile Justice		
<input type="checkbox"/> Outreach Project: (Select Type)	<input type="checkbox"/> Law Enforcement/ Police		
Number of times approached by outreach prior to entering the project? _____	<input type="checkbox"/> Mental Hospital		
<input type="checkbox"/> Temporary Shelter	<input type="checkbox"/> School		
<input type="checkbox"/> Residential Shelter	<input type="checkbox"/> Other Organization		
<input type="checkbox"/> Hotline	<input type="checkbox"/> Client Doesn't Know		
<input type="checkbox"/> Client Refused			
<b>Critical Issue</b>		<b>Status</b>	
Unemployment - Family member		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mental Health Issues- Family member		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Physical Disability –Family member		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Alcohol or Substance Abuse –Family member		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Insufficient Income to support youth - Family member		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Incarcerated Parent of Youth		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Formally a Ward of the System</b>			
<b>System</b>	<b>Formerly Ward of</b>	<b>Number of Years</b>	<b>If less than a year (Number of Months)</b>
Child Welfare/Foster Care Agency	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Less than one year <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 3 to 5 years or more	
Juvenile Justice System	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Less than one year <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 3 to 5 years or more	