

## ICA Missouri – RHY Update – ES-HP [FY2024]

Adult/HoH

Form designed for use by RHY-funded Basic Center Program shelter and prevention projects.

Staff: \_\_\_\_\_ Project Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Name of Head of Household: \_\_\_\_\_

Project Name (Enter Data As): \_\_\_\_\_

**Client Record**

Unless specifically required by a funder, clients may use a preferred name (rather than legal name) for HMIS purposes.

Name \_\_\_\_\_

First Middle Last Suffix

**Client location as of assessment/review date**

Select the county in which the client is residing (or sleeping at night if unhoused). This field does not need to match the CoC Code above.

Client Location (County) \_\_\_\_\_

**RHY Basic Center Program Status**

Date of Status Determination \_\_\_\_/\_\_\_\_/\_\_\_\_

Youth Eligible for RHY Services	<input type="checkbox"/> No <input type="checkbox"/> Yes
If no, reason why services are not funded by BCP grant	<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
If yes, runaway youth	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer

**Health Insurance**Covered by Health Insurance ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

Medicaid (MO HealthNet)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Medicare	<input type="checkbox"/> No <input type="checkbox"/> Yes
State Children's Health Insurance Program	<input type="checkbox"/> No <input type="checkbox"/> Yes
Veteran's Health Administration	<input type="checkbox"/> No <input type="checkbox"/> Yes
Employer-Provided Health Insurance	<input type="checkbox"/> No <input type="checkbox"/> Yes
Health Insurance obtained through COBRA	<input type="checkbox"/> No <input type="checkbox"/> Yes
Private Pay Health Insurance	<input type="checkbox"/> No <input type="checkbox"/> Yes
State Health Insurance for Adults	<input type="checkbox"/> No <input type="checkbox"/> Yes
Indian Health Services Program	<input type="checkbox"/> No <input type="checkbox"/> Yes
Other (specify): _____	<input type="checkbox"/> No <input type="checkbox"/> Yes



HUD requires that the client be asked about each individual source of health insurance and requires an answer be recorded for each.

**Data Entry Tip:**  
Remember to end date old records and create new records each time a source of health insurance changes.

## Monthly Income

**Income from Any Source** ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

Alimony and other spousal support	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Child support	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Earned income (i.e., employment income)	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
General Assistance (GA)	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Other (specify): _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Pension or retirement income from a former job	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Private disability insurance	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Retirement Income from Social Security	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Social Security Disability Insurance (SSDI)	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Supplemental Security Income (SSI)	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Temporary Assistance for Needy Families (TANF)	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Unemployment Insurance	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
VA Non-Service-Connected Disability Pension	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
VA Service-Connected Disability Compensation	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____
Worker's Compensation	<input type="checkbox"/> No	<input type="checkbox"/> Yes: \$ _____

**Total Monthly Income** \$ \_\_\_\_\_



HUD requires that the client be asked about each individual source of income and requires an answer be recorded for each. For any income sources where income is received, the monthly amount must also be recorded.



**Data Entry Tip:**  
Remember to end date old records and create new records each time a source of income changes.

## Non-Cash Benefits

**Non-Cash Benefits from Any Source** ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

Supplemental Nutrition Assistance Program (SNAP) (Previously known as Food Stamps)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
TANF Child Care services	<input type="checkbox"/> No	<input type="checkbox"/> Yes
TANF transportation services	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Other TANF-funded services	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Other (specify): _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes



HUD requires that the client be asked about each individual source of non-cash benefits and requires an answer be recorded for each.



**Data Entry Tip:**  
Remember to end date old records and create new records each time a source of non-cash benefit changes.

## Health

**Pregnancy Status** ☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer

If yes, due date \_\_\_\_/\_\_\_\_/\_\_\_\_

## Disabilities

- If one or more of the options below with an asterisk(\*) has been selected, the answer to "disabling condition" must be "yes."  
If none of the answers below with an asterisk(\*) has been selected, the answer to "disabling condition" may be "yes" or "no."

Disability type	Disability determination	If yes, expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?
Alcohol Use Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA
Both Alcohol and Drug Use Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA
Chronic Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA
Developmental Disability	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	(not applicable)
Drug Use Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA
HIV/AIDS	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	(not applicable)
Mental Health Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA
Physical Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> PNTA

DK = Client doesn't know; PNTA = Client prefers not to answer

## **Domestic Violence**



“Domestic violence” is utilized here as shorthand for domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions that relate to violence against the individual or a family member.

**Survivor of Domestic Violence?**   ☐ No   ☐ Yes   ☐ Client doesn't know   ☐ Client prefers not to answer

**If yes, when experience occurred**

☐ Within the past three months

☐ Three to six months ago

☐ From six to twelve months ago

☐ More than a year ago

☐ Client doesn't know

☐ Client prefers not to answer

**If yes, currently fleeing?**

☐ No

☐ Yes

☐ Client doesn't know

☐ Client prefers not to answer

***BE SURE TO LOG ANY RHY SPECIFIC SERVICES THAT WERE PROVIDED AT THE TIME OF ENTRY!***