

# RHY Update Form

Client Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Program \_\_\_\_\_ Date Effective: \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>Client has had recent changes in their:</b> <input type="checkbox"/> Employment Status <input type="checkbox"/> Income/Health Insurance <input type="checkbox"/> Disability Status <input type="checkbox"/> Housing Status	<b>Employment Status</b>	
	<b>Is client Employed or Unemployed?</b> <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed	<b>If <u>employed</u>, type of employment?</b> <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <b>Hours per week?</b> _____ <b>Where?</b> _____

Monthly Income			
Received in Past 30 Days?		Received in Past 30 Days?	
\$ _____ Earned income (ie. employment income)	Yes / No	\$ _____ Alimony or other spousal support	Yes / No
\$ _____ Pension from a former job (including military retirement pay)	Yes / No	\$ _____ SSI	Yes / No
\$ _____ Private disability insurance	Yes / No	\$ _____ SSDI	Yes / No
\$ _____ Child support	Yes / No	\$ _____ General Assistance	Yes / No
\$ _____ Unemployment insurance	Yes / No	\$ _____ TANF	Yes / No
\$ _____ Worker's compensation	Yes / No	\$ _____ Other Income Source: _____	Yes / No
\$ _____ Parent/Partner	Yes / No	<b>Total Monthly Income: \$ _____ (please indicate if \$0)</b>	
\$ _____ Student Financial Aid	Yes / No		

Non Cash Benefits	Health Insurance
Received in Past 30 Days?	Currently covered?
- Supplemental Nutrition Assistance Program (Food stamps) <span style="float: right;">Yes / No</span>	- Medicaid/Medi-Cal <span style="float: right;">Yes / No</span>
- TANF Child Care Services <span style="float: right;">Yes / No</span>	- MEDICARE <span style="float: right;">Yes / No</span>
- TANF Transportation Services <span style="float: right;">Yes / No</span>	- State Children's Health Insurance Program (SCHIP) <span style="float: right;">Yes / No</span>
- Other TANF-funded services <span style="float: right;">Yes / No</span>	- Veteran's Administration (VA) Medical Services <span style="float: right;">Yes / No</span>
- WIC <span style="float: right;">Yes / No</span>	- Employer-provided Health Insurance <span style="float: right;">Yes / No</span>
- Section 8, public housing, or other ongoing rental assistance <span style="float: right;">Yes / No</span>	- Health insurance obtained through COBRA <span style="float: right;">Yes / No</span>
- Temporary rental assistance <span style="float: right;">Yes / No</span>	- Private Pay Health Insurance <span style="float: right;">Yes / No</span>
- Other _____ <span style="float: right;">Yes / No</span>	- State Health Insurance for Adults <span style="float: right;">Yes / No</span>
	- Indian Health Services Program <span style="float: right;">Yes / No</span>

**Are you pregnant?**  Yes  No

**Have you ever willingly performed or been threatened/coerced/manipulated to perform a sexual act in exchange for money/goods?**  Yes  No

**If yes:**

- Has it been in the past 3 months?  Yes  No  Client doesn't know  Client refused
- How many times?  1-3  4-7  8-11  12 or more  Client doesn't know  Client refused
- Did someone ask/make you have sex?  Yes  No  Client doesn't know  Client refused

**Has it been in the past 3 months?**  Yes  No

**Ever been afraid to quit/leave work due to threats of violence to you or your family/friends?**  Yes  No  Client doesn't know  Client refused

**Ever been promised work where the work or payment ended up being different than what you expected?**  Yes  No  Client doesn't know  Refused

**If yes to either of the above, did you feel forced/pressured/tricked into continuing this job?**  Yes  No  Client doesn't know  Client refused

**Have you had any jobs like these in the last 3 months?**  Yes  No  Client doesn't know  Client refused

Disabilities					
	Yes/No	Long term?		Yes/No	Long term?
Physical			Mental health problem		
Developmental			Alcohol abuse		
Chronic health condition			Drug abuse		
HIV/AIDS			Other		

Housing Status Updates		
<b>Housing Status:</b> <input type="checkbox"/> Category 1 – Homeless (i.e. streets, shelter, transitional housing) <input type="checkbox"/> Category 2 – At imminent risk of losing housing (within 14 days) <input type="checkbox"/> Category 3 – Homeless only under other federal statutes <input type="checkbox"/> Category 4 – Fleeing domestic violence <input type="checkbox"/> At-risk of homelessness <input type="checkbox"/> Stably housed <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused		
<b>Housing Placement or New Housing Situation:</b> <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Permanent housing for formerly homeless persons (without RRH) <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Place not meant for habitation (vehicle, abandoned bldg, train station/airport, or anywhere outside) <input type="checkbox"/> Safe haven <input type="checkbox"/> Jail, prison, or juvenile detention facility <input type="checkbox"/> Rental by client, without RRH or equivalent 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 other ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <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"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Other _____ <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused		
<b>*For RRH and Permanent Housing Program use only: Housing Move-in Date:</b> ____/____/____ (mm/dd/yy)		
Address: _____ City _____ State _____ Zip _____ If client entered into a Program, Program Name: _____		