DC | DEPARTMENT of HUMAN SERVICES

Youth HOPE Triage Form

The Youth HOPE Program in collaboration with Sasha Bruce mission is to divert youth from shelters and promote housing stability and reunification by exploring youth support system (Nuclear family, extended family, friends or identified role models who can offer stability.

YOUTH INFORMATION				
Youth's Name (Legal Name):		Preferred Name/Alias (Nickname):		Preferred pronoun:
HMIS ID#		Date of Assessment	TAY-SPDAT Score	Full SPDAT Score
Date of Birth	Age	Social Security #	Gender ☐ Male ☐ Female ☐ Not reported	Identity ☐ Lesbian ☐ Bi-Sexual ☐ Gay ☐ Queer/Questioning
			Transgender: ☐ Male-Female ☐ Female-Male	
Phone Number		Email	Other Contact Information	

Ethnicity
☐ Hispanic / Latinx ☐ Non-Hispanic / Latinx

Race
☐ African American / Black ☐ White / Caucasian ☐ Alaska Native
☐ American Indian ☐ Native Hawaiian or other Pacific Islander ☐ Asian ☐ Other:

Citizenship Status
What is your citizenship status? ☐ Citizen ☐ Permanent Legal Resident ☐ Asylee, Refugee or other Eligible Immigrant ☐ Refused

BACKGROUND		
Youth Last Known Address and Contact: Do you agree to reunification and or stabilization with identified housing support: ☐ Yes ☐ No	Is your safety at risk? ☐ Yes ☐ No If yes, please explain:	Do you have a place to stay tonight? ☐ Yes ☐ No Location: Contact Name: Contact Number:
Self Referral: ☐ Yes ☐ No Referring Agency: Referring Name: Contact number:		Health Insurance:

Where did you stay last night: What is your safety plan for tonight: When was your last meal: Where do you plan to eat tonight:	Have you been to a Drop-in Center: ☐ Yes ☐ No Location: Service(s) provided: 1.	Are you receiving case management services from another agency? ☐ Yes ☐ No Contact Name: _____
Please List three Family/Friend network of support (name & number): 1. Name:_____ Number: _____ 2. Name:_____ Number: _____ **3.** Name:_____ Number: _____	2. 3.	Contact Number: _____

STRONGLY DISAGREE: Mark if you feel strongly against the statement or strongly feel the statement is not true.
DISAGREE: Mark if you feel you cannot support statement or feel statement is not true.
AGREE: Mark if you support the statement or feel this statement is true some of the time.
STRONGLY AGREE: Mark if you strongly support the statement or feel the statement is true most or all the time.

My family is supportive of my life goals	**Strongly Disagree**	**Disagree**	**Agree**	**Strongly Agree**
I wish my family and I would get along better	☐	☐	☐	☐
I have thought seriously about ending my relationship with my Family	☐	☐	☐	☐
This is very stressful time for me and my family	☐	☐	☐	☐
At times I feel out of control, like I'm losing it when speaking to my identified supports	☐	☐	☐	☐
Uncontrolled anger can be a problem in my family	☐	☐	☐	☐

Do I have your consent to share this information with other agencies within the continuum of care?
☐ Yes ☐ No

SERVICES REQUESTED

☐ Food Gift Card	☐ Transportation
☐ Hygiene Kit	☐ Reunification/ Stabilization
☐ Clothing	☐ Individual Therapy
☐ Medical/Mental Health Referral	☐ Job Assistance
☐ Substance Abuse Referral	☐ Immigration Assistance
☐ Dental Referral	☐ Legal Assistance
☐ Vital Record Assistance	☐ Education Assistance
☐ Respite Care	☐ Benefit Application Assistance (SSI/SSDI)
☐ Family Counseling	

Intake Summary (Synopsis of participation, fulfillment of individual service request, current living situation, employment and education plan, including next steps, if applicable):

☐ Staff completing form
Name: _____ Title: _____ Phone: _____

Email: _____

☐ Data entered in HMIS
☐ Copy placed in client file
☐ Comments:

Email: Strengtheningfoundations@sashabruce.org **or** **Submit**

For Office Use:

Intake Date:	Follow up Date:	Assigned to: