**ServicePoint Intake – for Dependent Children <18 ServicePoint ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Client’s Name:**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  \_\_\_\_\_ Full name \_\_\_\_\_Partial, street or code name \_\_\_\_\_Client doesn’t know \_\_\_\_\_Client refused | | | | | | | |
| **Social Security Number (SSN)** :**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  \_\_\_\_\_Full SSN \_\_\_\_\_Approx. or partial SSN \_\_\_\_\_Client doesn’t know \_\_\_\_\_Client refused | | | | | | | |
| **Client’s relationship to head of household:** | | | | | | | |
| **ROI Page 1** (Overall Record Sharing): \_\_\_\_\_Yes \_\_\_\_\_No **(IF NO, CLOSE MAIN RECORD PADLOCK)** | | | | | | | |
| **Does client have a disability of long duration:** \_\_\_\_\_\_Yes \_\_\_\_\_\_No \_\_\_\_\_Client doesn’t know \_\_\_\_\_Client refused | | | | | | | |
| **Circle below for each disability type: Y=Y N=No DK=Doesn’t Know R=Refused** | | | | | | | |
| **Disability Type** | Has disability | | **IF YES:** | Expected to be of long continued and indefinite duration AND substantially impairs ability to live independently | | | |
| **Alcohol abuse** | Y N DK R | | Y N DK R | | | |
| **Drug Abuse** | Y N DK R | | Y N DK R | | | |
| **Both alcohol and drug abuse** | Y N DK R | | Y N DK R | | | |
| **Chronic health condition** | Y N DK R | | Y N DK R | | | |
| **Developmental disability** | Y N DK R | | Y N DK R | | | |
| **HIV/AIDS** | Y N DK R | | Y N DK R | | | |
| **Mental health problem** | Y N DK R | | Y N DK R | | | |
| **Physical disability** | Y N DK R | | Y N DK R | | | |
| **HUD Relationship to Head of Household**:  \_\_\_\_\_Head of Household’s other relation member \_\_\_\_\_Other: Non-relation member  \_\_\_\_\_Head of Household’s Child \_\_\_\_\_Client doesn’t know  \_\_\_\_\_Client refused | | | | | | | |
| **Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  \_\_\_\_Full DOB \_\_\_\_Approx.DOB \_\_\_\_Client doesn’t know \_\_\_\_Client refused | | | | | | | |
| **Race** (check up to 2):  \_\_\_\_\_American Indian or Alaska Native \_\_\_\_\_Asian \_\_\_\_\_Black or African American  \_\_\_\_\_Native Hawaiian/Pacific Islander \_\_\_\_\_White  \_\_\_\_\_Client doesn’t know \_\_\_\_\_Client refused | | | | | | | |
| **Gender**: \_\_\_\_\_Female \_\_\_\_\_Male \_\_\_\_\_Client refused \_\_\_\_\_Client doesn’t know  \_\_\_\_\_Transgender M to F \_\_\_\_\_Transgender F to M \_\_\_\_\_Does Not Identify as M/F/T | | | | | | | |
| **Ethnicity**: \_\_\_\_\_Non-Hispanic/Non-Latino \_\_\_\_\_Hispanic/Latino \_\_\_\_\_Client doesn’t know \_\_\_\_\_Client refused | | | | | | | |
| **Covered by health insurance**:\_\_\_\_\_\_Yes \_\_\_\_\_\_No \_\_\_\_\_Client doesn’t know \_\_\_\_\_Client refused | | | | | | | |
| Type: | | Yes | | No | Type: | Yes | No |
| MEDICAID | |  | |  | Employer-provided insurance |  |  |
| MEDICARE | |  | |  | Health insurance through COBRA |  |  |
| State children’s health insurance | |  | |  | Private pay health insurance |  |  |
| Veteran’s Admin. medical services | |  | |  | State health insurance for adults |  |  |
| Indian Health Services Program | |  | |  | Other: |  |  |