**HMIS Intake – for Children in Household under 18** Head of Household Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Date Child Entered Project: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_** |
| **Social Security Number (SSN):** (write in SSN and check 1 data quality option): **\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_**  [ ] Full SSN [ ] Approx. or partial SSN [ ] Client doesn’t know [ ] Client prefers not to answer  [ ] Data not collected |
| **Child’s First and Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** [ ] Full name [ ] Partial, street, or code name [ ] Client doesn’t know [ ] Client prefers not to answer  [ ] Data not collected  |
| **Date of Birth (DOB): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**  [ ] Full DOB [ ] Approx. or partial DOB [ ] Client doesn’t know [ ] Client prefers not to answer  [ ] Data not collected |
| **Gender** (check all that apply):  [ ] Woman (Girl, if child) [ ] Man (Boy, if child) [ ] Culturally Specific Identity (e.g., Two-Spirit) [ ] Transgender [ ] Non-Binary [ ] Questioning  [ ] Different Identity [ ] Client doesn’t know [ ] Client prefers not to answer [ ] Data not collected**If Different Identity, please specify:** |
| **Race and Ethnicity** (check all that apply): [ ] American Indian, Alaska Native, or Indigenous [ ] Asian or Asian American  [ ] Black, African American, or African [ ] Hispanic/Latina/e/o  [ ] Middle Eastern or North African [ ] Native Hawaiian or Pacific Islander  [ ] White [ ] Client doesn’t know  [ ] Client prefers not to answer [ ] Data not collected**Additional Race and Ethnicity Detail** (if client would like to share additional info about their race or ethnicity, add here): |
| ***Disabling Condition:***Does the client have a disabling condition? [ ] Yes [ ] No [ ] Client doesn’t know [ ] Client prefers not to answer [ ] Data not collected  |
| Circle below for each disability type: Y=Yes N=No DK=Doesn’t know PN=Prefers not to answer NC=Not collected |
| **Disability Type** | **Disability Determination** **(Has disability)** | **IF YES:** | Expected to be of long continued and indefinite duration and substantially impairs ability to live independently and of such a nature that such ability could be improved by more suitable housing conditions. |
| Physical Disability  | Y N DK PN NC |  | Y N DK PN NC |
| Developmental Disability  | Y N DK PN NC |  | N/A |
| Chronic Health Condition  | Y N DK PN NC |  | Y N DK PN NC |
| HIV/AIDS | Y N DK PN NC |  | N/A |
| Mental Health Disorder | Y N DK PN NC |  | Y N DK PN NC |
| Alcohol Use Disorder | Y N DK PN NC |  | Y N DK PN NC |
| Drug Use Disorder | Y N DK PN NC |  | Y N DK PN NC |
| Both Alcohol & Drug Use Disorder | Y N DK PN NC |  | Y N DK PN NC |
| ***Health Insurance***Is the client covered by health insurance? [ ] Yes [ ] No [ ] Client doesn’t know [ ] Client prefers not to answer [ ] Data not collected  |
| **Yes** (Check box) | **Health Insurance Type** |
| [ ]  | MEDICAID |
| [ ]  | MEDICARE |
| [ ]  | State Children’s Health Insurance Program |
| [ ]  | Veteran’s Health Administration (VHA) |
|[ ]  Employer-Provided Health Insurance |
| [ ]  | Health Insurance Obtained Through COBRA |
| [ ]  | Private Pay Health Insurance |
| [ ]  | State Health Insurance for Adults |
| [ ]  | Indian Health Services Program |
|[ ]  Other Health Insurance (please specify): |