

HMIS #
CM Name
Project Entry Date / /

**Santa Barbara County HMIS Standard Intake - CHILD**

This form is designed to be completed by a service provider while interviewing a client.

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| **Household Information**  Is client:  Child |
| **If Checked ChildName Of HoH** | First Name: | Last Name: |
| **If you are in a household, what is your relationship to the HoH?** | Self (head of household)Head of household’s childHead of household’s spouse or partner | Other: relation to head of householdOther: non-relation member |
| **Client Profile**  |
| **Social Security Number** |  |  |
| **First Name** |  | **Middle** |
| **Last Name** |  |  |
| **Alias** |  |
| **Quality of Name** |  Full Name Reported Partial, Street Name, or CodeName Reported |  Client Doesn’t Know Client Refused |
| **Primary Phone Number** |  |  |

A separate Standard Intake form should be completed for each member of the household.

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| **Client Demographics**  |
| **Date of Birth** |  / /  |  |
| **Gender** |  Female  Male  Trans Female (MTF or Male to Female) Trans Male (FTM or Female to Male) | Gender Non-Conforming (i.e. not exclusively male or female) Client Doesn’t Know  Client Refused |
| **Ethnicity** Non-Hispanic/Non-Latino Hispanic/Latino Client Doesn’t Know  Client Refused | **Race**American Indian or Alaska NativeAsian  Black or African American  |  Native Hawaiian or Other Pacific Islander White Client Doesn’t Know  Client Refused |

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| **Disabilities**  |
| **Does the client have a disabling condition?** |  Yes No |  Client Doesn’t Know  Client Refused |
| **If Yes, please complete the following for each disability type** |
| **Alcohol Abuse**  Yes  No Client Doesn’t Know Client Refused**Start Date:** / /  | If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently. |  Yes  No Client Doesn’t Know Client Refused |
| **Both Alcohol and Drug Abuse** Yes  No Client Doesn’t Know Client Refused**Start Date:** / /  | If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently. |  Yes  No Client Doesn’t Know Client Refused |
| **Chronic Health Condition** Yes  No Client Doesn’t Know Client Refused**Start Date:** / /  | If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently. |  Yes  No Client Doesn’t Know Client Refused |
| **Developmental**  Yes  No Client Doesn’t Know Client Refused**Start Date:** / /  | If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently. |  Yes  No Client Doesn’t Know Client Refused |

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| **Disabilities** |
| **Drug Abuse** Yes  No Client Doesn’t Know Client Refused**Start Date:** / /  | If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently. |  Yes  No Client Doesn’t Know Client Refused |
| **HIV/AIDS**  Yes  No Client Doesn’t Know Client Refused**Start Date:** / /  | If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently |  Yes  No Client Doesn’t Know Client Refused |
| **Mental Health Problem** Yes  No Client Doesn’t Know Client Refused**Start Date:** / /  | If Yes, if the problem is expected to be of long-continued and indefinite duration and substantially impedes a client’s ability to live independently. |  Yes  No Client Doesn’t Know Client Refused |
| **Physical** Yes  No Client Doesn’t Know Client Refused**Start Date:** / /  | If Yes, if the problem is expected to be of long-continued and indefinite duration and substantially impedes a client’s ability to live independently. |  Yes  No Client Doesn’t Know Client Refused |

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| **Health Insurance** |
| **Covered by health insurance?** | Yes No Client doesn’t know Client refused |
|  Medicaid Medicare State Children’s Health Insurance Program Veteran’s Administration (VA) Medical Services Employer-Provided Health Insurance |  Health Insurance Obtained Through COBRA Private Pay Health Insurance State Health Insurance for Adults Indian Health Services Program Other Health InsuranceIf Other Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

I, (Adult client or Head of Household) certify that the information I have provided here is true/correct to the best of my knowledge.

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| Print Name of Client | Signature of Client | Date |
| Print Name of Intake Worker | Signature of Intake Worker | Date |