

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 Child Name 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 Code Name 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 Insurance  If 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 |