

HMIS #
CM Name
Project Start Date / /

**Santa Cruz County HMIS YHDP 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?** | HusbandWifeDaughterSonFather MotherSisterBrotherRoommateGrandchild | AuntUncleNieceNephewGrandparentSignificant OtherDomestic PartnerOtherStepdaughterStepson |
| **Client Profile**  |
| **Social Security Number** |  |  |
| **First Name** |  | **Middle** |
| **Last Name** |  |  |
| **Alias(es)** (Separated by commas) |  |
| **Quality of Name** |  Full Name Reported Partial, Street Name, or CodeName Reported |  Client Doesn’t Know Client Refused |
| **Disabling Condition** |  Yes  No |  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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| **Prior Living Situation** |
| **Prior Street Address** |  |
|  **Prior City** |  |
| **Prior State** |  |  | **Prior Zip Code** |
| **Prior Address Data Quality** | Full Address ReportedIncomplete or Estimated Address Reported |  Client Doesn’t Know Client Refused |

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| **Disabling Conditions and Barriers/Domestic Violence** |
| **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** |
| **Physical Disability** Yes  No Client Doesn’t Know Client Refused | Condition Long Term?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 |
| **Developmental Disability** |  Yes  No Client Doesn’t Know Client Refused |
| **Chronic Health Condition** Yes  No Client Doesn’t Know Client Refused | Condition Long Term?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 |
| **HIV - AIDS** |  Yes  No Client Doesn’t Know Client Refused |  |
| **Mental Health Problem** Yes  No Client Doesn’t Know Client Refused | Condition Long Term?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 |
| **Substance Abuse Problem** No  Alcohol Abuse Drug Abuse Both Alcohol & Drug Abuse Client Doesn’t Know Client Refused | Condition Long Term?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 |
| **Domestic Violence Victim/Survivor** Yes  No Client Doesn’t Know Client Refused | Last OccurrenceHow long ago did the person have the most recent experience? |  Within the past three months  Three to six months ago (excluding six months exactly) Six months to one year ago (excluding one year exactly) One year ago or more Client Doesn’t Know Client Refused |
| **Are You Currently Fleeing?** | Are you currently fleeing domestic violence? |  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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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| **YHDP Specific Information** |
| **Sexual Orientation** |  HeterosexualGay Lesbian BisexualQuestioning / Unsure |  Other If Other Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Doesn’t Know  Client Refused |
| **School Status** |  Attending school regularly Attending school irregularly Graduated from high school Obtained GED |  Suspended ExpelledQuestioning / Unsure Client Doesn’t Know  Client Refused |
| **General Health** |  Excellent Very good Good Fair |  Poor Client Doesn’t Know  Client Refused |
| **Mental Health** |  Excellent Very good Good Fair |  Poor Client Doesn’t Know  Client Refused |
| **Pregnancy Status** (For female applicants) Yes No  Client Doesn’t Know Client Refused | **If YesDue Date:**\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_ |  |
| **Formerly a Ward of Child Welfare or Foster Care Agency** Yes No  Client Doesn’t Know Client Refused | **If Yes:Number of Years** Less than one year 1 to 2 years 3 to 5 or more years | **If less than one year:****Number of Months (1-11)**\_\_\_\_\_\_\_\_\_\_ |
| **Formerly a Ward of the Juvenile Justice System** Yes No  Client Doesn’t Know Client Refused | **If Yes:Number of Years** Less than one year 1 to 2 years 3 to 5 or more years | **If less than one year:****Number of Months (1-11)**\_\_\_\_\_\_\_\_\_\_ |

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 |