

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 Child Name 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 Code Name 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 Occurrence  How 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 Insurance  If 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 Yes Due 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 |