COMMUNITY TECHNOLOGY ALLIANCE

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

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		

Client Demographics

Date of Birth	____/____/____	
Gender (multi-select)	❑ Female ❑ Male ❑ A gender that is not singularly 'Female' or 'Male' ❑ Transgender	❑ Questioning ❑ Client Doesn't Know ❑ Client Refused
Ethnicity ❑ Non-Hispanic/Non-Latino ❑ Hispanic/Latino ❑ Client Doesn't Know ❑ Client Refused	**Race** ❑ American Indian, Alaska Native, or Indigenous ❑ Asian or Asian American ❑Black, African American, or African	❑ Native Hawaiian or Pacific Islander ❑ White ❑ Client Doesn't Know ❑ Client Refused

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 use disorder ❑ 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 Use Disorder ❑ 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 Disability ❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused **Start Date:**____/____/____		
Substance Use Disorder ❑ 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:**____/____/____		
Mental Health Disorder ❑ 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 Disability ❑ 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

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.

Print Name of Client	Signature of Client	Date

Print Name of Intake Worker	Signature of Intake Worker	Date