

# 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 should be completed for each member of the household.

HMIS # \_\_\_\_\_

CM Name: \_\_\_\_\_

Project Entry Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Household Information

Check if client is a child: ☐ Child

Who is the head of household (HoH)?

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

What is your relationship to the HoH?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Self (head of household)             | <input type="checkbox"/> Head of household's child  | <input type="checkbox"/> Head of household's spouse or partner |
| <input type="checkbox"/> Other: relation to head of household | <input type="checkbox"/> Other: non-relation member |  |

### Client Profile

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Alias: \_\_\_\_\_

Quality of Name:

- |  |   |
|--|---|
| <input type="checkbox"/> Full name reported  | <input type="checkbox"/> Partial, Street Name or Code name reported                               |
| <input type="checkbox"/> Client doesn't know | <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected |

Social Security Number: \_\_\_\_/\_\_\_\_/\_\_\_\_ May collect last 4 numbers instead of all 9 numbers

### Child Demographics

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender (select as many as applicable)

- |   |   |   |                                      |
|---|---|---|--------------------------------------|
| <input type="checkbox"/> Woman (Girl, if child) | <input type="checkbox"/> Culturally Specific          | <input type="checkbox"/> Non-Binary                   | <input type="checkbox"/> Questioning |
| <input type="checkbox"/> Man (Boy, if child)    | <input type="checkbox"/> Transgender                  | <input type="checkbox"/> Different Identity: specify: |                                      |
| <input type="checkbox"/> Client doesn't know    | <input type="checkbox"/> Client prefers not to answer | <input type="checkbox"/> Data not collected           |                                      |

Race & Ethnicity:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> American Indian, Alaska Native, or Indigenous | <input type="checkbox"/> Black, African American, or African |   |
| <input type="checkbox"/> Asian or Asian American                       | <input type="checkbox"/> Hispanic/Latina/e/o                 |   |
| <input type="checkbox"/> Middle Eastern or North African               | <input type="checkbox"/> Native Hawaiian or Pacific Islander | <input type="checkbox"/> White              |
| <input type="checkbox"/> Client doesn't know                           | <input type="checkbox"/> Client prefers not to answer        | <input type="checkbox"/> Data not collected |

Additional Race & Ethnicity Details (optional):

## Disability

### Does the client have a disabling condition?

☐ Yes    |    ☐ No    |    ☐ Client doesn't know    |    ☐ Client prefers not to answer    |    ☐ Data not collected

Disability Type/Determination	Condition Long Term?	Disability Start Date
<b>Alcohol Use Disorder</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	____/____/____
<b>Both Alcohol &amp; Drug Use Disorder</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	____/____/____
<b>Chronic Health Condition</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	____/____/____
<b>Developmental</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	____/____/____
<b>Substance Use Disorder</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	____/____/____
<b>HIV/AIDS</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	____/____/____
<b>Mental Health Disorder</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	____/____/____
<b>Physical</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected	____/____/____

## Health Insurance

**Covered by Health Insurance?**

☐ Yes    |    ☐ No    |    ☐ Client doesn't know    |    ☐ Client prefers not to answer    |    ☐ Data not collected

Type of Health Insurance	State Date Receiving
<input type="checkbox"/> Employer provided health insurance	____/____/____
<input type="checkbox"/> Health insurance obtained through COBRA	____/____/____
<input type="checkbox"/> Indian Health Services program	____/____/____
<input type="checkbox"/> Medicare	____/____/____
<input type="checkbox"/> Medicaid	____/____/____
<input type="checkbox"/> Private pay health plan	____/____/____
<input type="checkbox"/> State children's health insurance program	____/____/____
<input type="checkbox"/> State health insurance for adults	____/____/____
<input type="checkbox"/> VA Health Administration (VHA)	____/____/____
<input type="checkbox"/> Other Source	____/____/____

If "Other Source", specify: \_\_\_\_\_

## Signatures

**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