Merced County
HMIS Standard Intake – CHILD

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?

❑ 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

First Name: _____ Middle Name: _____ Last Name: _____

Alias: _____

Quality of Name:

❑ Full name reported	❑ Partial, Street Name or Code name reported	
❑ Client doesn't know	❑ Client prefers not to answer	❑ 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)

❑ Woman (Girl, if child)	❑ Culturally Specific	❑ Non-Binary	❑ Questioning
❑ Man (Boy, if child)	❑ Transgender	❑ Different Identity: specify:	
❑ Client doesn't know	❑ Client prefers not to answer	❑ Data not collected	

Race & Ethnicity:

❑ American Indian, Alaska Native, or Indigenous	❑ Black, African American, or African	
❑ Asian or Asian American	❑ Hispanic/Latina/e/o	
❑ Middle Eastern or North African	❑ Native Hawaiian or Pacific Islander	❑ White
❑ Client doesn't know	❑ Client prefers not to answer	❑ 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
Alcohol Use Disorder ❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data not collected	❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data not collected	_____/_____/_____
Both Alcohol & Drug Use Disorder ❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data not collected	❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data not collected	_____/_____/_____
Chronic Health Condition ❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data not collected	❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data not collected	_____/_____/_____
Developmental ❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data not collected	❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data not collected	_____/_____/_____
Substance Use Disorder ❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data not collected	❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data not collected	_____/_____/_____
HIV/AIDS ❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data not collected	❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data not collected	_____/_____/_____
Mental Health Disorder ❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data not collected	❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data not collected	_____/_____/_____
Physical ❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer ❑ Data not collected	❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer ❑ 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
❑ Employer provided health insurance	_____/_____/_____
❑ Health insurance obtained through COBRA	_____/_____/_____
❑ Indian Health Services program	_____/_____/_____
❑ Medicare	_____/_____/_____
❑ Medicaid	_____/_____/_____
❑ Private pay health plan	_____/_____/_____
❑ State children's health insurance program	_____/_____/_____
❑ State health insurance for adults	_____/_____/_____
❑ VA Health Administration (VHA)	_____/_____/_____
❑ 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**