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FY2024- Children Intake Form (Children in Households under 18 years old)
(Please complete this form for ALL Children under 18 years of age)

Client Name: _____ HMIS Client ID#: _____(optional)
Project Start Date: _____
SS#: _ _ _ - _ _ - _ _ _ _ **DOB**___/___/_____ **Zip Code of Last Permanent Address:** _____

Race and Ethnicity: (Select as many as client identifies)
____ American Indian/ Alaska Native or Indigenous
____ Asian or Asian American
____ Black, African American, or African
____ Hispanic/Latina/e/o
____ Middle Eastern or North African
____ Native Hawaiian or Pacific Islander
____ White
Additional Race and Ethnicity Detail: _____

Gender: (Select as many as client identifies)
____ Woman (Girl, if child)
____ Man (Boy, If child)
____ Culturally Specific Identity (e.g., Two-Spirit)
____ Transgender (clients who live or identify with a transgender history, experience, or identity)
____ Non-Binary
____ Questioning (Unsure, may be exploring, or may not relate to or identify with a gender identity at this time)
____ Different Identity; **Please Specify**: _____

Relationship to Head of Household:
____ Head of Household's Child
____ Head of Household's Spouse/ Partner
____ Head of Household's Other Relation Member
____ Other: Non-Relation Member

Preffered Language: ____Arabic ____Armenian ____Bangali ____Catonese ____Chinese ____English ____French ____French Creole ____German ____Greek ____Gujarati ____Hatian Creole ____Hebrew ____Hindi ____Hmong ____Italian ____Japanese ____Korean ____Mandarin ____Panjabi ____Persian ____Polish ____Portuguese ____Russian ____Spanish ____Tagalog ____Telugu ____Urdu ____Vietnamese ____Yiddish

Translation Assistance Needed:
__ No
__ Yes

Do you have Health Insurance/ Medical Assistance? ____Yes ____ No
Source of Health Insurance/ Medical Assistance:

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_____ Medicaid _____ Medicare _____ State Children's Health Insurance Program
_____ Veteran's Administration (VA) Medical Services _____ Employer – Provided Health Insurance
_____ Health Insurance obtained through COBRA _____ State Health Insurance for Adults
_____ Indian Health Care _____ Other

Medicaid ID# _____
Medicaid Insurance Company: ____ Total Care ____ Blue Cross Blue Shield ____ Fidelis
____ United Healthcare ____ Molina Healthcare

Disabling Condition:

Do you have a DISABILITY of long duration? ____Yes ____ No

For each disability, check "LCI" if it is expected to be of long, continued and indefinite duration, substantially impairs the individual's ability to live independently, and is of such a nature that such ability could be improved by more suitable housing conditions.

Disability Type:

__Yes __LCI Alcohol Use Disorder __Yes__LCI BOTH Alcohol & Drug Use Disorder __Yes__LCI Drug Use Disorder
__Yes__LCI Chronic Health Condition __Yes__LCI Developmental _____ HIV/AIDS
__Yes__LCI Mental Health Disorder __Yes__LCI Physical Health

Date of Engagement: ___/___/___ (Complete upon client entering Service Plan development or fully completed initial assessment)

Housing Move In Date: ___/___/___ (Complete if moving into PERMANENT HOUSING {RRH, PSH or OPH})