# HMIS Universal Intake Form - Child

**Completed By:** _____ **Program:** _____ **Shelter Bed #:** _____

**Project Start/Entry In Date *(all clients)*** _____

*mm/dd/yyyy*

## *Client Demographics*

**Name *(all clients)***

| | |
|---|---|
| First Name | |
| Middle Name | |
| Last Name | |
| Suffix | |

Phone #: _____

**Name Data Quality *(all clients)***

- ☐ Full Name Reported
- ☐ Partial, street name, or code name reported
- ☐ Client doesn't know
- ☐ Client refused

**Military Veteran (active military duty)**

- ☐ Yes
- ☑ No
- ☐ Client doesn't know
- ☐ Client refused

**Social Security Number *(all clients)***

_____

**Date of Birth *(all clients)***

_____

*mm/dd/yyyy*

**SSN Data Quality *(all clients)***

- ☐ Full SSN Reported
- ☐ Approximate or partial SSN reported
- ☐ Client doesn't know
- ☐ Client refused

**DOB Data Quality *(all clients)***

- ☐ Full DOB Reported
- ☐ Approximate or partial DOB reported
- ☐ Client doesn't know
- ☐ Client refused

**Race: Check all that apply *(all clients)***

- ☐ American Indian, Alaskan Native, or Indigenous
- ☐ Asian or Asian American
- ☐ Black, African American, or African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Client doesn't know
- ☐ Client refused

**Ethnicity *(all clients)***

- ☐ Non-Hispanic/Non-Latin(a)(o)(x)
- ☐ Hispanic/Latin(a)(o)(x)
- ☐ Client doesn't know
- ☐ Client refused

**Gender *(all clients)***

- ☐ Female
- ☐ Male
- ☐ A Gender Other than Singularly Female or Male (e.g. Non-Binary, Genderfluid, Agender, Culturally Specific Gender)
- ☐ Transgender
- ☐ Questioning
- ☐ Client doesn't know
- ☐ Client refused

## *Household Information*

**Relationship to Head of Household**

- ☐ Self (Head of Household)
- ☐ Head of household's child
- ☐ Head of household's other relation member (other relation to head of household)
- ☐ Head of household's spouse or partner
- ☐ Other: non-relation member

**Client Location (CoC Code):** **OH-503**

## *Disabling Conditions (all clients)*

**Does the client have a disabiling condition?**

☐ No ☐ Yes ☐ Client doesn't know ☐ Client refused

### Physical

| | Long term? |
|---|---|
| ☐ No ☐ Yes | ☐ No ☐ Yes |
| ☐ Client doesn't know | ☐ Client doesn't know |
| ☐ Client refused | ☐ Client refused |

### Developmental

- ☐ No ☐ Yes
- ☐ Client doesn't know
- ☐ Client refused

### Chronic Health

| | Long term? |
|---|---|
| ☐ No ☐ Yes | ☐ No ☐ Yes |
| ☐ Client doesn't know | ☐ Client doesn't know |
| ☐ Client refused | ☐ Client refused |

### HIV

- ☐ No ☐ Yes
- ☐ Client doesn't know
- ☐ Client refused

### Mental Health

| | Long term? |
|---|---|
| ☐ No ☐ Yes | ☐ No ☐ Yes |
| ☐ Client doesn't know | ☐ Client doesn't know |
| ☐ Client refused | ☐ Client refused |

### Alcohol Use Disorder

| | Long term? |
|---|---|
| ☐ No ☐ Yes | ☐ No ☐ Yes |
| ☐ Client doesn't know | ☐ Client doesn't know |
| ☐ Client refused | ☐ Client refused |

### Drug Abuse

| | Long term? |
|---|---|
| ☐ No ☐ Yes | ☐ No ☐ Yes |
| ☐ Client doesn't know | ☐ Client doesn't know |
| ☐ Client refused | ☐ Client refused |

### Both Alcohol/Drug

| | Long term? |
|---|---|
| ☐ No ☐ Yes | ☐ No ☐ Yes |
| ☐ Client doesn't know | ☐ Client doesn't know |
| ☐ Client refused | ☐ Client refused |

## *Health Insurance*

**Covered by health insurance** ***(all clients)***

- ☐ Yes
- ☐ No
- ☐ Client doesn't know
- ☐ Client refused

**Answer 'Yes' or 'No' for each health insurance source.**
**(Based on the status at the time of entry)**

| No | Yes | Source of insurance coverage |
|---|---|---|
| ☐ | ☐ | 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 (or use local name) |
| ☐ | ☐ | Indian Health Services Program |
| ☐ | ☐ | Other source: _____ |