HMIS Universal Intake Form - Child

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

Project Start/Entry In Date *(all clients)*   ☐☐ / ☐☐ / ☐☐☐☐
                  month   *day*   *year*

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)*

☐☐ / ☐☐ / ☐☐☐☐
month   *day*   *year*

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 disabling 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: _____