2023 HMIS Child Intake Form

RESPOND TO THE FOLLOWING QUESTIONS FOR THE HEAD OF HOUSEHOLD AND EACH ADDITIONAL ADULT IN THE HOUSEHOLD. IF THE HOUSEHOLD IS COMPOSED OF AN UNACCOMPANIED CHILD, THAT CHILD IS THE HEAD OF HOUSEHOLD. IF THE HOUSEHOLD IS COMPOSED OF TWO OR MORE MINORS, DATA MUST BE COLLECTED ABOUT THE MINOR THAT HAS BEEN DESIGNATED AS THE HEAD OF HOUSEHOLD. A SEPARATE FORM SHOULD BE INCLUDED FOR EACH ADULT MEMBER OF THE HOUSEHOLD.

Date of Intake _____

CLIENT'S NAME		**N/A**
Last		☐
First		
Middle		☐
Suffix		☐

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

DATE OF BIRTH	___ / ___ / ___ (Month / Day / Year)	**Age:**

QUALITY OF DOB

☐ Full DOB reported	☐ Approximate or partial DOB reported	☐ Client doesn't know	☐ Client Prefers Not to Answer	☐ Data not collected

SOCIAL SECURITY NUMBER (SSN)	

QUALITY OF SSN

☐ Full SSN reported	☐ Approximate or partial SSN reported	☐ Client doesn't know	☐ Client Prefers Not to Answer	☐ Data not collected

GENDER

☐ Man (Boy if child) ☐ Woman (Girl, if child) ☐ Culturally specific Identity (e.g., Two-Spirit) ☐ Different Identity	☐ Non-Binary ☐ Transgender ☐ Questioning	☐ Client doesn't know ☐ Client Prefers Not to Answer ☐ Data not collected

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RACE AND ETHNICITY

☐ 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	☐ Client doesn't know ☐ Client Prefers Not to Answer ☐ Data not collected

RELATIONSHIP TO HEAD OF HOUSEHOLD

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

PROJECT NAME	
PROJECT START DATE	____ — ____ — ____

Disabling Condition	☐ No ☐ Client doesn't know ☐ Client Prefers Not to Answer ☐ Yes ☐ Data not collected

Covered by Health Insurance?	☐ No ☐ Client doesn't know ☐ Client Prefers Not to Answer ☐ Yes ☐ Data not collected

Substance Use Disorder	
No	
Alcohol Use Disorder	
Drug Use Disorder	
Both Alcohol and Drug Use Disorders	
Client doesn't know	
Client Prefers Not to Answer	
Data not collected	

Mental Health Disorder	
No	
Yes	
Client doesn't know	
Client Prefers Not to Answer	
Data not collected	

Developmental Disability	
No	
Yes	
Client doesn't know	
Client Prefers Not to Answer	
Data not collected	

Chronic Health Condition	
No	
Yes	
Client doesn't know	
Client Prefers Not to Answer	
Data not collected	

HIV / AIDS	
No	
Yes	
Client doesn't know	
Client Prefers Not to Answer	
Data not collected	

Physical Disability	
No	
Yes	
Client doesn't know	
Client Prefers Not to Answer	
Data not collected	

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Covered by Health Insurance?	□ No □ Yes □ Client doesn't know □ Client Prefers Not to Answer □ Data not collected
IF "YES" TO COVERED BY HEALTH INSURANCE– INDICATE ALL SOURCES THAT APPLY	
□ MEDICAID	□ Insurance Obtained through COBRA
□ MEDICARE	□ Private Pay Health Insurance
□ State Children's Health Insurance Program	□ State Health Insurance for Adults
□ Veteran's Administration (VA) Medical Services	□ Indian Health Services Program
□ Employer-provided Health Insurance	□ Other Health Insurance (Specify Source):_____

Client Verification

I understand that this document is an application for assistance and that the agency, participating in the West TN Continuum of Care, must review this application before deciding whether to assist me with the program. The agency agrees to notify me as soon as possible of its decision**. I certify that the information provided by me on this application, as well as information provided by me regarding the income and assets of members of my family unit, is true to the best of my knowledge**. I hereby promise to report any changes in this information that may occur while my case is open.

Client's Name _____

Client's Signature _____

Date_____/_____/_____

When applicable:

I, _____ have a received a copy of the following:

_____1. Grievance and Termination Policy
_____2. Fair Housing Information Packet
_____3. Lead Base Paint Information Packet
_____4. Copy of Statement and Understanding

Client's Signature _____Date_____/_____/_____

Parent or Guardian Signature_____

Date_____