THE COALITION
OF HOMELESS SERVICES PROVIDERS

HMIS # _____
CM Name _____
Project Start Date ____/____/____

Monterey/ San Benito County HMIS Standard Intake - CHILD

This form is designed to be completed by a service provider while interviewing a client.
A separate Standard Intake form should be completed for each member of the household.

Household Information Is client: ☒ Child

If Checked Child Name Of HoH	First Name:	Last Name:
If you are in a household, what is your relationship to the HoH?	❑Husband ❑Wife ❑Daughter ❑Son ❑Father ❑Mother ❑Sister ❑Brother ❑Roommate ❑Grandchild	❑Aunt ❑Uncle ❑Niece ❑Nephew ❑Grandparent ❑Significant Other ❑Domestic Partner ❑Other ❑Stepdaughter ❑Stepson

Client Profile

Social Security Number		
First Name		**Middle**
Last Name		
Alias(es) (Separated by commas)		
Quality of Name	❑ Full Name Reported ❑ Partial, Street Name, or Code Name Reported	❑ Client Doesn't Know ❑ Client Refused
Disabling Condition	❑ Yes ❑ No	❑ Client Doesn't Know ❑ Client Refused
Primary Phone Number		

Client Demographics

Date of Birth	_____/_____/_____	
Gender	❑ Female ❑ Male ❑ Trans Female (MTF or Male to Female) ❑ Trans Male (FTM or Female to Male)	❑Gender Non-Conforming (i.e. not exclusively male or female) ❑ Client Doesn't Know ❑ Client Refused
Ethnicity ❑ Non-Hispanic/Non-Latino ❑ Hispanic/Latino ❑ Client Doesn't Know ❑ Client Refused	**Race** ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American	❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Client Doesn't Know ❑ Client Refused

Prior Living Situation

Prior Street Address		
Prior City		
Prior State		**Prior Zip Code**
Prior Address Data Quality	❑Full Address Reported ❑Incomplete or Estimated Address Reported	❑ Client Doesn't Know ❑ Client Refused

Disabling Conditions and Barriers

Does the client have a disabling condition?	❑ Yes ❑ No	❑ Client Doesn't Know ❑ Client Refused
If Yes, please complete the following for each disability type		
Alcohol Abuse ❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	Condition Long Term? If Yes, If the problem is expected to be of long-continued and indefinite duration and substantially impedes a client's ability to live independently.	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Drug Abuse ❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	Condition Long Term? If Yes, If the problem is expected to be of long-continued and indefinite duration and substantially impedes a client's ability to live independently.	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Both Alcohol & Drug Abuse ❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	Condition Long Term? If Yes, If the problem is expected to be of long-continued and indefinite duration and substantially impedes a client's ability to live independently.	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Chronic Health Condition ❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	Condition Long Term? If Yes, If the problem is expected to be of long-continued and indefinite duration and substantially impedes a client's ability to live independently.	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Developmental Disability	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	

Disabling Conditions and Barriers

Physical Disability ❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	Condition Long Term? ❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused If Yes, If the problem is expected to be of long-continued and indefinite duration and substantially impedes a client's ability to live independently.
HIV - AIDS	❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused
Mental Health Problem ❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused	Condition Long Term? ❑ Yes ❑ No ❑ Client Doesn't Know ❑ Client Refused If Yes, If the problem is expected to be of long-continued and indefinite duration and substantially impedes a client's ability to live independently.

Health Insurance

Covered by health insurance?	❑ Yes ❑ No ❑ Client doesn't know ❑ Client refused
❑ Medicaid	❑ Health 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 If Other Specify: _____

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