



Agency Name _____

COHMIS Child Intake Form
For all non-RHY projects

PROJECT START DATE *[All Children]*

		-				-				
Month			Day			Year				

SOCIAL SECURITY NUMBER *[All Children]*

			-			-				
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QUALITY OF SOCIAL SECURITY

<input type="radio"/>	Full SSN reported	<input type="radio"/>	Client doesn't know
		<input type="radio"/>	Client refused
<input type="radio"/>	Approximate or partial SSN reported	<input type="radio"/>	Data not collected

CURRENT NAME *[All Children]*

																		N/A
Last																		
First																		
Middle																		<input type="radio"/>
Suffix																		<input type="radio"/>
Alias																		<input type="radio"/>

QUALITY OF CURRENT NAME

<input type="radio"/>	Full name reported	<input type="radio"/>	Client doesn't know
		<input type="radio"/>	Client refused
<input type="radio"/>	Partial, street name, or code name reported	<input type="radio"/>	Data not collected

DATE OF BIRTH *[All Children]*

		-			-					Age:
Month			Day			Year				

QUALITY OF DATE OF BIRTH

<input type="radio"/>	Full DOB reported	<input type="radio"/>	Client doesn't know
		<input type="radio"/>	Client refused
<input type="radio"/>	Approximate or partial DOB reported	<input type="radio"/>	Data not collected

GENDER *[All Children]*

<input type="radio"/>	Female	<input type="radio"/>	Client doesn't know
<input type="radio"/>	Male	<input type="radio"/>	Client refused
<input type="radio"/>	Trans Female (MTF or Male to Female)	<input type="radio"/>	Data not collected
<input type="radio"/>	Trans Male (FTM or Female to Male)		
<input type="radio"/>	Gender Non-Conforming (i.e. not exclusively male or female)		



RACE (Select all applicable) *[All Children]*

<input type="checkbox"/>	American Indian or Alaskan Native	<input type="checkbox"/>	Client does not know
<input type="checkbox"/>	Asian	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Black/African American	<input type="checkbox"/>	Data Not Collected
<input type="checkbox"/>	Hawaiian or Other Pacific Islander		
<input type="checkbox"/>	White/Caucasian		

ETHNICITY *[All Children]*

<input type="checkbox"/>	Non-Hispanic/ Non-Latino	<input type="checkbox"/>	Client does not know
		<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Hispanic/Latino	<input type="checkbox"/>	Data Not Collected
		<input type="checkbox"/>	Other

RELATIONSHIP TO HEAD OF HOUSEHOLD *[All Children]*

<input type="checkbox"/>	Head of household's child
<input type="checkbox"/>	Head of household – other relation to member
<input type="checkbox"/>	Other: non-relation member

DISABLING CONDITION *[All Children]*

<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused
		<input type="checkbox"/>	Data not collected

PHYSICAL DISABILITY *[All Children except SSVF programs]*

<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused
		<input type="checkbox"/>	Data not collected

IF "YES" TO PHYSICAL DISABILITY – SPECIFY

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know
	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused
			<input type="checkbox"/>	Data not collected

DEVELOPMENTAL DISABILITY *[All Children except SSVF programs]*

<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused
		<input type="checkbox"/>	Data not collected

IF "YES" TO DEVELOPMENTAL DISABILITY – SPECIFY

Expected to substantially impair ability to live independently?	<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know
	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused
			<input type="checkbox"/>	Data not collected

CHRONIC HEALTH CONDITION *[All Children except SSVF programs]*

<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused
		<input type="checkbox"/>	Data not collected

IF "YES" TO CHRONIC HEALTH CONDITION – SPECIFY

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know
	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client refused
			<input type="checkbox"/>	Data not collected



HIV-AIDS [All Children except SSVF programs]

<input type="radio"/>	No	<input type="radio"/>	Client doesn't know	
<input type="radio"/>	Yes	<input type="radio"/>	Client refused	
		<input type="radio"/>	Data not collected	
IF "YES" TO HIV-AIDS – SPECIFY				
Expected to substantially impair ability to live independently?	<input type="radio"/>	No	<input type="radio"/>	Client doesn't know
	<input type="radio"/>	Yes	<input type="radio"/>	Client refused
			<input type="radio"/>	Data not collected

MENTAL HEALTH PROBLEM [All Children except SSVF programs]

<input type="radio"/>	No	<input type="radio"/>	Client doesn't know	
<input type="radio"/>	Yes	<input type="radio"/>	Client refused	
		<input type="radio"/>	Data not collected	
IF "YES" TO MENTAL HEALTH CONDITION – SPECIFY				
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	<input type="radio"/>	No	<input type="radio"/>	Client doesn't know
	<input type="radio"/>	Yes	<input type="radio"/>	Client refused
			<input type="radio"/>	Data not collected

SUBSTANCE ABUSE PROBLEM [All Children except SSVF programs]

<input type="radio"/>	No	<input type="radio"/>	Both alcohol and drug abuse	
<input type="radio"/>	Alcohol abuse	<input type="radio"/>	Client doesn't know	
		<input type="radio"/>	Client refused	
<input type="radio"/>	Drug abuse	<input type="radio"/>	Data not collected	
IF "ALCOHOL ABUSE" "DRUG ABUSE" OR "BOTH ALCOHOL AND DRUG ABUSE" – SPECIFY				
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	<input type="radio"/>	No	<input type="radio"/>	Client doesn't know
	<input type="radio"/>	Yes	<input type="radio"/>	Client refused
			<input type="radio"/>	Data not collected

COVERED BY HEALTH INSURANCE [All Children]

<input type="radio"/>	No	<input type="radio"/>	Client doesn't know
<input type="radio"/>	Yes	<input type="radio"/>	Client refused
		<input type="radio"/>	Data not collected
IF "YES" TO HEALTH INSURANCE - HEALTH INSURANCE COVERAGE DETAILS			
<input type="radio"/>	MEDICAID	<input type="radio"/>	Employer Provided Health Insurance
<input type="radio"/>	MEDICARE	<input type="radio"/>	Insurance Obtained through COBRA
<input type="radio"/>	State Children's Health Insurance (SCHIP)	<input type="radio"/>	Private Pay Health Insurance
<input type="radio"/>	Veteran's Administration (VA) Medical Services	<input type="radio"/>	State Health Insurance for Adults
<input type="radio"/>	Other (specify):	<input type="radio"/>	Indian Health Services Program

Signature of parent or guardian stating all information is true and correct Date