COHMIS

Child Intake Form

For all non-RHY funded projects

SOCIAL SECURITY NUMBER (SSN)				▓			▓				

QUALITY OF SSN	☐ Full SSN reported ☐ Approximate/partial SSN reported	☐ Client doesn't know ☐ Client refused ☐ Data not collected

CLIENT NAME

Last:		Alias:	
First:			
Middle:		Suffix:	

QUALITY OF NAME	☐ Full name reported ☐ Partial, street name, or code name reported	☐ Client doesn't know ☐ Client refused ☐ Data not collected

DATE OF BIRTH (DOB) (MM/DD/YYYY)			▓			▓				

QUALITY OF DOB	☐ Full DOB reported ☐ Approximate/partial DOB reported	☐ Client doesn't know ☐ Client refused ☐ Data not collected

GENDER

☐ Female ☐ Male	☐ A gender that is not singularly 'Female' or 'Male' ☐ Transgender ☐ Questioning	☐ Client doesn't know ☐ Client refused ☐ Data not collected

RACE

☐ American Indian, Alaska Native, or Indigenous ☐ Asian or Asian American	☐ Black, African American, or African ☐ Native Hawaiian or Other Pacific Islander ☐ White	☐ Client doesn't know ☐ Client refused ☐ Data not collected

ETHNICITY

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

RELATIONSHIP TO 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 (MM/DD/YYYY)			▓			▓				

DISABLING CONDITION	
☐ No ☐ Yes	☐ Client doesn't know ☐ Client refused ☐ Data not collected

PHYSICAL DISABILITY		
☐ No ☐ Yes*	☐ Client doesn't know ☐ Client refused ☐ Data not collected	
*If YES for Physical Disability *Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?*	☐ No ☐ Yes	☐ Client doesn't know ☐ Client refused ☐ Data not collected

DEVELOPMENTAL DISABILITY	
☐ No ☐ Yes	☐ Client doesn't know ☐ Client refused ☐ Data not collected

CHRONIC HEALTH CONDITION		
☐ No ☐ Yes*	☐ Client doesn't know ☐ Client refused ☐ Data not collected	
*If YES for Chronic Health Condition *Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?*	☐ No ☐ Yes	☐ Client doesn't know ☐ Client refused ☐ Data not collected

HIV/AIDS	
☐ No ☐ Yes	☐ Client doesn't know ☐ Client refused ☐ Data not collected

MENTAL HEALTH DISORDER		
☐ No ☐ Yes*	☐ Client doesn't know ☐ Client refused ☐ Data not collected	
*If YES for Mental Health Disorder *Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?*	☐ No ☐ Yes	☐ Client doesn't know ☐ Client refused ☐ Data not collected

SUBSTANCE USE DISORDER		
☐ No ☐ Alcohol use disorder ☐ Drug use disorder ☐ Both alcohol and drug use disorder	☐ Client doesn't know ☐ Client refused ☐ Data not collected	
*If YES for Substance Use Disorder *Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?*	☐ No ☐ Yes	☐ Client doesn't know ☐ Client refused ☐ Data not collected

HEALTH INSURANCE		
Covered by Health Insurance?	☐ No ☐ Yes*	☐ Client doesn't know ☐ Client refused ☐ Data not collected
*If YES to Covered by Health Insurance – Indicate all sources that apply		
☐ 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 ☐ Indian Health Services Program ☐ Other Health Insurance (Specify source:_____)	

_____   _____

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