

HMIS Intake and Enrollment Form Child- All Programs

Client ID: _____

Project Name: _____

Staff Completing Form: _____

For all children entering HMIS project type: **All HMIS projects**

Identification - All fields required unless otherwise noted

First Name _____ Middle Name _____
Last Name _____ Suffix _____

Name Data Quality: <small>Did the client provide their full name?</small>	Social Security Number (SSN)	Birth Date (DOB)
<input type="checkbox"/> Full Name Reported <input type="checkbox"/> Partial, street name, or code name reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	_____ - _____ - _____ <input type="checkbox"/> Full SSN reported <input type="checkbox"/> Approximate or partial SSN reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	____/____/____ <input type="checkbox"/> Approximate or partial DOB reported <input type="checkbox"/> Full DOB reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused

Name of Head of Household: _____

Basic Demographics – All fields required unless otherwise noted

Race (Check all that apply)	Ethnicity
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/ Non-Latino <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused
Gender	Relationship to Head of Household
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans Male (Female to Male) <input type="checkbox"/> Trans Female (Male to Female) <input type="checkbox"/> Gender Non-Conforming (Not exclusively Male or Female) <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Dependent Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other: Family Member <input type="checkbox"/> Other: Non-Family Member
Health Insurance	Health Insurance Sources
<input type="checkbox"/> Yes (Enter the Source) <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> MEDICAID <input type="checkbox"/> State Children's Health Insurance(SCHIP) <input type="checkbox"/> VA Medical Services <input type="checkbox"/> Employer Provided Health Insurance <input type="checkbox"/> Health Insurance obtained through COBRA <input type="checkbox"/> State Health Insurance Adults (Medi-cal) <input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Other: _____
Disabling Condition	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	

Project Start Date _____/_____/_____

Barriers (All programs except SSVF)

	Barrier Present	Condition is Indefinite
Alcohol Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
Chronic Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
Developmental Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	
Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	
Mental health	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused
Physical Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Client Refused