HMIS Intake and Enrollment Form
Child- All Programs

Client ID: _____
Project Name: _____
Staff Completing HMIS form _____

For all children entering HMIS project type: ***All HMIS projects*** ☐ *Also for entering CES Enrollment*

Identification *- All fields required unless otherwise noted*

First Name _____ **Middle Name** _____

Last Name **Suffix**

Name Data Quality: Did the client provide their full name?	**Social Security Number (SSN)** _____-_____-_____	**Birth Date (DOB)** _____/_____/_____
□ Full Name Reported □ Partial, street name, or code name reported □ Client Doesn't Know □ Client Refused	□ Full SSN reported □ Approximate or partial SSN reported □ Client Doesn't Know □ Client Refused	□ Approximate or partial DOB reported □ Full DOB reported □ Client Doesn't Know □ Client Refused

Name of Head of Household: _____

Relationship to Head of Household			
	□ Self	□ Dependent Child	□ Other: Non-Family Member
	□ Son	□ Spouse	
	□ Daughter	□ Other: Family Member	

Basic Demographics – All fields required unless otherwise noted

Ethnicity

□ **Hispanic/Latino(a)(o)(x)** □ **Non-Hispanic/ Non-Latino(a)(o)(x)** □ **Client Doesn't Know** □ **Client Refused**

Race (Check all that apply)

□ **American Indian, Alaska Native, or Indigenous**
□ **Asian or Asian American**
□ **Black, African American, or African**
□ **Native Hawaiian or Pacific Islander**
□ **White**
□ **Client Doesn't Know**
□ **Client Refused**

Gender **Client authorizes update in HMIS if gender is different?** □ Yes □ No

□ **Female**
□ **Male**
□ **A gender other than singularly female or male(e.g., non-binary, genderfluid, agender, culturally specific gender)**
□ **Transgender**
□ **Questioning**
□ **Client Doesn't Know**
□ **Client Refused**

Health Insurance

□Yes (Enter the Source)	□ No	□ Client Doesn't Know	□ Client Refused
Health Insurance Sources	□ Private Pay Health Insurance □ Medicare □ MEDICAID □ State Children's Health Insurance (SCHIP) □ VA Medical Services		□ Employer Provided Health Insurance □ Health Insurance obtained through COBRA □ State Health Insurance Adults (Medi-cal) □ Indian Health Services Program □ Other _____
Disabling Condition	□ Yes	□ No	□ Client Doesn't Know □ Client Refused

Barriers (All programs except SSVF)

	Barrier Present	**Condition is Indefinite**
Alcohol Use Disorder	□ Yes □ No □ Don't Know □ Client Refused	□ Yes □ No □ Don't Know □ Client Refused
Chronic Health Condition	□ Yes □ No □ Don't Know □ Client Refused	□ Yes □ No □ Don't Know □ Client Refused
Developmental Disability	□ Yes □ No □ Don't Know □ Client Refused	
Drug Use Disorder	□ Yes □ No □ Don't Know □ Client Refused	□ Yes □ No □ Don't Know □ Client Refused
HIV/AIDS	□ Yes □ No □ Don't Know □ Client Refused	
Mental Health Disorder	□ Yes □ No □ Don't Know □ Client Refused	□ Yes □ No □ Don't Know □ Client Refused
Physical Disability	□ Yes □ No □ Don't Know □ Client Refused	□ Yes □ No □ Don't Know □ Client Refused
Project Start Date	_____/_____/_____	