NorCal HMIS Minor Intake Form

Please fill out (1) form for each child

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Agency Case No:** |  |  |  |  |  |  | **Service Point Client No:** |  |  |
| **1. Head of Household Information** |
| Intake Date | Month | Day |  | Year |  |  |  | Name of HOH: |
|  | SSN: | DOB: |
| **2. Household Relationship** |
| **Relationship to Head of Household** |  Brother  Granddaughter Daughter  Grandfather Daughter-in-law  Grandmother Father  Grandson Father-in-law  Husband Foster’s daughter  Mother Foster’s son  Mother-in-law |  |  |  |  Nephew  Son Niece  Son-in-law Other non-relative  Step-daughter Other relative  Step-son Self  Unknown Significant other  Wife Sister |  |
| **3. Client Information** |
| First | Middle | Last | Suffix |
| Alias |  |
| **SSN** | **- -** | **Gender** |  Woman (Girl, if child)  Man (Boy, if child) Culturally Specific Identity (e.g., Two-Spirit) Transgender Non-Binary Questioning Different Identity |
| **SSN Data Quality** |  Full Reported Partial/Approx. Reported Client doesn’t know Client refused |
| **Date of Birth** | Month | Day | Year |  |  |  |  |  |
| **DOB Data Quality** |  Full Reported Partial/Approx. Reported Client doesn’t know. Client refused |
| **Race and Ethnicity** |  American Indian, Alaska Native, or Indigenous Asian, or Asian American Black, African American, or African Hispanic/Latina/e/o Middle Eastern or Northern African Native Hawaiian or Pacific Islander White | **Disabling Condition?** |  Yes No Client doesn’t know Client refused |
| **Zip Code of Last Permanent Address** |  | **Zip Data Quality** |  Full Reported Partial/Approx. Reported Client doesn’t know. Client refused |
| **4. Monthly Income/Non-Cash Benefits/Health Insurance/Disabilities** |
| **Income from any source:** |  Yes  No (*If yes, Please record on HoH Intake.)* |
| **Covered by Health Insurance:** |  Yes  No  Client doesn’t know  Client refused |
| **Health Insurance Type:** |  MEDICAID/MEDI-CAL  MEDICARE  Employer – Provided Health Insurance  State Health Insurance for Adults  | State Children’s Health Insurance Program  VA Medical ServicesHealth Insurance obtained through COBRA  Private Pay Health Insurance Indian Health Services Program  Other |
| **Disability Type:** | **Determination** | **If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?** |
| Alcohol Use Disorder |  Yes  No | Start Date: |  |  |  |  Yes  No  Client doesn’t know  Client refused |
| Both Alcohol and Drug Use Disorder |  Yes  No | Start Date: |  |  |  |  Yes  No  Client doesn’t know  Client refused |
| Chronic Health Condition |  Yes  No | Start Date: |  |  |  |  Yes  No  Client doesn’t know  Client refused |
| Developmental |  Yes  No | Start Date: |  |  |  |  Yes  No  Client doesn’t know  Client refused |
| Drug Abuse |  Yes  No | Start Date: |  |  |  |  Yes  No  Client doesn’t know  Client refused |
| HIV/AIDS |  Yes  No | Start Date: |  |  |  |  Yes  No  Client doesn’t know  Client refused |
| Mental Health Disorder |  Yes  No | Start Date: |  |  |  |  Yes  No  Client doesn’t know  Client refused |
| Physical |  Yes  No | Start Date: |  |  |  |  Yes  No  Client doesn’t know  Client refused |

\*Please make sure to get a RELEASE OF INFORMATION (ROI) signed for each additional adult Household member. \*