



COHMIS

Child Intake Form

For all non-RHY funded projects

SOCIAL SECURITY NUMBER (SSN)									
QUALITY OF SSN		<input type="checkbox"/> Full SSN reported <input type="checkbox"/> Approximate/partial SSN reported				<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected			
CLIENT NAME									
Last:					Alias:				
First:									
Middle:					Suffix:				
QUALITY OF NAME		<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"/> Data not collected			
DATE OF BIRTH (DOB) (MM/DD/YYYY)									
QUALITY OF DOB		<input type="checkbox"/> Full DOB reported <input type="checkbox"/> Approximate/partial DOB reported				<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected			
GENDER									
<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> A gender that is not singularly 'Female' or 'Male' <input type="checkbox"/> Transgender <input type="checkbox"/> Questioning				<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected			
RACE									
<input type="checkbox"/> American Indian, Alaska Native, or Indigenous <input type="checkbox"/> Asian or Asian American		<input type="checkbox"/> Black, African American, or African <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"/> Data not collected			
ETHNICITY									
<input type="checkbox"/> Non-Hispanic/Non-Latin(a)(o)(x) <input type="checkbox"/> Hispanic/Latin(a)(o)(x)						<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected			
RELATIONSHIP TO HEAD OF HOUSEHOLD									
<input type="checkbox"/> Head of household's child <input type="checkbox"/> Head of household's spouse or partner		<input type="checkbox"/> Head of household's other relation member <input type="checkbox"/> Other: non-relation member							

PROJECT NAME									
PROJECT START DATE (MM/DD/YYYY)									

DISABLING CONDITION	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
PHYSICAL DISABILITY	
<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
*If YES for Physical Disability <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
DEVELOPMENTAL DISABILITY	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
CHRONIC HEALTH CONDITION	
<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
*If YES for Chronic Health Condition <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
HIV/AIDS	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
MENTAL HEALTH DISORDER	
<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
*If YES for Mental Health Disorder <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
SUBSTANCE USE DISORDER	
<input type="checkbox"/> No <input type="checkbox"/> Alcohol use disorder <input type="checkbox"/> Drug use disorder <input type="checkbox"/> Both alcohol and drug use disorder	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
*If YES for Substance Use Disorder <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

HEALTH INSURANCE	
Covered by Health Insurance?	<input type="checkbox"/> No <input type="checkbox"/> Yes* <div style="float: right;"> <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected </div>
*If YES to Covered by Health Insurance – Indicate all sources that apply	
<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Veteran's Administration (VA) Medical Services <input type="checkbox"/> Employer-Provided Health Insurance	<input type="checkbox"/> Health Insurance Obtained Through COBRA <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Other Health Insurance (Specify source: _____)

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

Date