COHMIS

Child Intake Form

For all non-RHY funded projects

SOCIAL SECURITY NUMBER (SSN):				—			—					

Quality of SSN:

- ☐ Full SSN Reported
- ☐ Approximate or partial SSN reported
- ☐ Client doesn't know
- ☐ Client prefers not to answer
- ☐ Data not collected

CLIENT NAME

Last:			
First:			
Middle		Suffix:	

QUALITY OF NAME

- ☐ Full name reported
- ☐ Partial, street name or code name reported
- ☐ Client doesn't know
- ☐ Client prefers not to answer
- ☐ Data not collected

DATE OF BIRTH (DOB)			—			—				
	MONTH			**DAY**			**YEAR**			

QUALITY OF DOB

- ☐ Full DOB reported
- ☐ Approximate or partial DOB reported
- ☐ Client doesn't know
- ☐ Client prefers not to answer
- ☐ Data not collected

GENDER *(select all that apply)*

- ☐ Woman (Girl if child)
- ☐ Man (Boy if child)
- ☐ Culturally Specific Identity (e.g., Two Spirit)
- ☐ Transgender
- ☐ Non-binary
- ☐ Questioning
- ☐ Different Identity
- ☐ Client doesn't know
- ☐ Client prefers not to answer
- ☐ Data not collected

If different identity, please specify: _____

CLIENT PRONOUNS

- ☐ She/Her/Hers
- ☐ He/Him/His
- ☐ They/Them/Theirs
- ☐ Client doesn't know
- ☐ Client prefers not to answer
- ☐ Data not collected
- ☐ Other pronouns: _____

RACE/ETHNICTY *(select all that apply)*

- ☐ American Indian, Alaska Native, or Indigenous
- ☐ Asian or Asian American
- ☐ Black, African American, or African
- ☐ Hispanic/Latina/e/o
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Client doesn't know
- ☐ Client prefers not to answer
- ☐ Data not collected

Additional Race and Ethnicity Detail (optional): _____

RELATIONSHIP TO HEAD OF HOUSEHOLD

- ☐ Self (Head of Household)
- ☐ Head of Household's Child
- ☐ Head of Household's spouse or partner
- ☐ Head of household's other relation member
- ☐ Other: nonrelation member

PROJECT NAME											
PROJECT START DATE (mm/dd/yyyy)			—			—					

Disabling Condition		
☐ No ☐ Yes		☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
Physical Disability		
☐ No ☐ Yes*		☐ Client doesn't know ☐ Client prefers not to answer ☐ 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 prefers not to answer ☐ Data not collected
Developmental Disability		
☐ No ☐ Yes		☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
Chronic Health Condition		
☐ No ☐ Yes*		☐ Client doesn't know ☐ Client prefers not to answer ☐ 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 prefers not to answer ☐ Data not collected
HIV/AIDS		
☐ No ☐ Yes		☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
Mental Health Disorder		
☐ No ☐ Yes*		☐ Client doesn't know ☐ Client prefers not to answer ☐ 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 prefers not to answer ☐ Data not collected
Substance Use Disorder		
☐ No ☐ Alcohol Use Disorder* ☐ Drug Use Disorder* ☐ Both Alcohol and Drug Use Disorder*		☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected
*If **YES** for Mental Health Disorder	☐ No ☐ Yes	☐ Client doesn't know ☐ Client prefers not to answer

Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?	☐ Data not collected

HEALTH INSURANCE		
Covered by health insurance?	☐ No ☐ Yes*	☐ Client doesn't know ☐ Client prefers not to answer ☐ 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 Health Administration (VHA) ☐ 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