COHMIS

Child Intake Form

For all non-RHY funded projects

SOCIAL SECURITY NUMBER (SSN)	☐☐☐-☐☐-☐☐☐☐
QUALITY OF SSN	☐ Full SSN reported ☐ Approximate/partial SSN reported ☐ Client doesn't know ☐ Client refused ☐ 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 refused ☐ Data not collected
DATE OF BIRTH (DOB) (MM/DD/YYYY)	☐☐-☐☐-☐☐☐☐
QUALITY OF DOB	☐ Full DOB reported ☐ Approximate/partial DOB reported ☐ Client doesn't know ☐ Client refused ☐ Data not collected

GENDER

☐ Female
☐ Male
☐ Trans Female (MTF or Male to Female)
☐ Trans Male (FTM or Female to Male)
☐ Gender Non-Conforming (not exclusively male or female)
☐ Client doesn't know
☐ Client refused
☐ Data not collected

RACE

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander
☐ Asian
☐ Client doesn't know
☐ Client refused
☐ Data not collected

ETHNICITY

☐ Non-Hispanic/Non-Latino
☐ Hispanic/Latino
☐ Client doesn't know
☐ Client refused
☐ Data not collected

RELATIONSHIP TO HEAD OF HOUSEHOLD

☐ Head of household's child
☐ Head of household's spouse or partner
☐ Head of household's other relation member
☐ Other: non-relation member

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

DISABLING CONDITION

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

PHYSICAL DISABILITY

☐ No
☐ Yes*

☐ Client doesn't know
☐ Client refused
☐ 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 refused
☐ Data not collected

DEVELOPMENTAL DISABILITY

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

CHRONIC HEALTH CONDITION

☐ No
☐ Yes*

☐ Client doesn't know
☐ Client refused
☐ 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 refused
☐ Data not collected

HIV/AIDS

☐ No
☐ Yes

☐ Client doesn't know
☐ Client refused
☐ Data not collected

MENTAL HEALTH PROBLEM

☐ No
☐ Yes*

☐ Client doesn't know
☐ Client refused
☐ Data not collected

***If YES for Mental Health Problem**
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 refused
☐ Data not collected

SUBSTANCE ABUSE PROBLEM

☐ No
☐ Alcohol abuse
☐ Drug abuse
☐ Both alcohol and drug abuse

☐ Client doesn't know
☐ Client refused
☐ Data not collected

***If YES for Substance Abuse Problem**
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 refused
☐ Data not collected

HEALTH INSURANCE		
Covered by Health Insurance?	☐ No ☐ Yes*	☐ Client doesn't know ☐ Client refused ☐ Data not collected

***If YES to Covered by Health Insurance – Indicate all sources that apply**

☐ Medicaid	☐ Health Insurance Obtained Through COBRA
☐ Medicare	☐ Private Pay Health Insurance
☐ State Children's Health Insurance Program	☐ State Health Insurance for Adults
☐ Veteran's Administration (VA) Medical Services	☐ Indian Health Services Program
☐ Employer-Provided Health Insurance	☐ Other Health Insurance (Specify source:_____)

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

Date