*Team Name: _____

*Intake Date: ____/____/____

This intake is for use on children ages 0-17 yrs. only

Outreach HMIS Child Intake Form

CORE
Coordinated Outreach, Referral & Engagement

_____ _____ _____ _____ _____

*First Name Middle *Last Name Jr/Sr Nickname/Alias

_____ _____ _____ _____

*Social Security Number *Birth Date Age

Self / Child / Spouse or Partner / Other Non-Relative
*Relationship to Head of Household

F / M / Trans Female (MTF) / Trans Male (FTM) / Not exclusively either
*Gender

Heterosexual / Gay / Lesbian / Bisexual / Questioning or Unsure
*Sexual Orientation

***Ethnicity (check one)** ❑ Hispanic/Latino ❑ Non-Hispanic/Non-Latino ❑ Client doesn't know ❑ Client refused

***What Race BEST describes you? (circle all that apply)**

[Those of Latin heritage should mark American Indian if their ancestry is from North, South or Central America. Those from the Far East (including India) should mark Asian. Those from the Middle East should mark White.]

❑ American Indian/Alaskan Native ❑ Black/African American ❑ Client doesn't know ❑ Client refused
❑ Asian ❑ White ❑ Native Hawaiian/Pacific islander

*Health Insurance

Covered by Health Insurance? ☐ Yes ☐ No If yes, check all that apply

☐Medicaid ☐VA Medical ☐Private Pay Health Insurance ☐Other Health Insurance
☐Medicare ☐Employer-Provided Health Insurance ☐State Health Insurance for Adults Specify Other:
☐State Children's Health Insurance Program ☐COBRA ☐Indian Health Services Program _____

*Disabilities: Please circle Yes or No for EACH of the following

Physical	Yes / No	**Long Term?:** Yes / No	**Mental health problem**	Yes / No	**Long Term?:** Yes / No
Developmental	Yes / No	**Impairs Independence?** Yes / No	**Alcohol abuse**	Yes / No	**Long Term?:** Yes / No
Chronic health condition	Yes / No	**Long Term?:** Yes / No	**Drug abuse**	Yes / No	**Long Term?:** Yes / No
HIV/AIDS	Yes / No	**Impairs Independence?** Yes / No	**Both Alcohol and Drug Abuse**	Yes / No	**Long Term?:** Yes / No

Note: Chronic health condition – a diagnosed condition that is more than three months in duration and is either not curable or has residual effects that limit daily living and require adaptation in function or special assistance. Examples include but are not limited to: heart disease, severe asthma, diabetes, arthritis-related conditions, adult onset cognitive impairments (including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive related conditions), severe headache/migraine, cancer, chronic bronchitis, liver condition, stroke, or emphysema.

***Do you have a Disabling Condition? This means: Do you have a condition of expected long duration that substantially limits your ability to live on you own**

❑ Yes ❑ No ❑ Client doesn't know ❑ Client refused

***Present Living Situation (circle one):**

❑ Emergency shelter, including hotel or motel paid for with emergency shelter voucher
❑ Place not meant for habitation including non-housing service site
❑ Other:_____

If place not meant for habitation, specify below:

❑ Street/sidewalk ❑ Bus/train station
❑ Vehicle ❑ Under a bridge /overpass
❑ Park ❑ Outdoor encampment/ woods
❑ Abandoned building

***Length of present living situation (circle one):**

❑ One night or less
❑ Two nights to six nights
❑ One week or more, but less than one month
❑ One month or more, but less than 90 days
❑ 90 Days or more, but less than one year
❑ One year or longer
❑ Client doesn't Know
❑ Client refused

***If less than 30 days, where were you living before?** (See choices under Present Living Situation)_____

***Approximate date CURRENT episode of homelessness started (breaks of less than 7 days are acceptable)** ___ / ____ / _____

***Number of times you have been homeless on the streets/shelter in the PAST THREE YEARS including today:** _____

***Total Number of Months Homeless in the PAST THREE YEARS** [Note: Any single day or part of a month spent homeless should be counted as 1 month. Short breaks are acceptable]: _____ **months**

***City where you lost stable housing** _____ ***City Slept In Last Night:** _____

Emergency Contact Person _____**Phone No.** _____