

# KS BOS HMIS

## Child Intake Form

For all non-RHY funded projects

<b>SOCIAL SECURITY NUMBER (SSN)</b>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
<b>QUALITY OF SSN</b>		<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							
<b>CLIENT NAME</b>											
Last:		<input type="text"/>									
First:		<input type="text"/>									
Middle:		<input type="text"/>					Suffix:		<input type="text"/>		
<b>QUALITY OF NAME</b>		<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							
<b>DATE OF BIRTH (DOB) (MM/DD/YYYY)</b>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
<b>QUALITY OF DOB</b>		<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							
<b>GENDER</b>											
<input type="checkbox"/> Female <input type="checkbox"/> Male		<input type="checkbox"/> Trans Female (MTF or Male to Female) <input type="checkbox"/> Trans Male (FTM or Female to Male) <input type="checkbox"/> Gender Non-Conforming (not exclusively male or female)		<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected							
<b>RACE</b>											
<input type="checkbox"/> White <input type="checkbox"/> Black or African American		<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian		<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected							
<b>ETHNICITY</b>											
<input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Hispanic/Latino		<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected									
<b>RELATIONSHIP TO HEAD OF HOUSEHOLD</b>											
<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									

<b>PROJECT NAME</b>		<input type="text"/>							
<b>PROJECT START DATE (MM/DD/YYYY)</b>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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
<b>*If YES for Physical Disability</b> <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
<b>*If YES for Chronic Health Condition</b> <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 PROBLEM	
<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
<b>*If YES for Mental Health Problem</b> <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 ABUSE PROBLEM	
<input type="checkbox"/> No <input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Drug abuse <input type="checkbox"/> Both alcohol and drug abuse	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>*If YES for Substance Abuse Problem</b> <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	
<b>Covered by Health Insurance?</b>	<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>
<b>*If YES to Covered by Health Insurance – Indicate all sources that apply</b>	
<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: _____)

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

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Date