NorCal HMIS Minor Intake Form

Please fill out (1) form for each child

Agency Case No:	**Service Point Client No:**

1. Head of Household Information

Intake Date	Month Day Year	Name of HOH:
	SSN:	DOB:

2. Household Relationship

Relationship to Head of Household	☐ Brother	☐ Granddaughter	☐ Nephew	☐ Son
	☐ Daughter	☐ Grandfather	☐ Niece	☐ Son-in-law
	☐ Daughter-in-law	☐ Grandmother	☐ Other non-relative	☐ Step-daughter
	☐ Father	☐ Grandson	☐ Other relative	☐ Step-son
	☐ Father-in-law	☐ Husband	☐ Self	☐ Unknown
	☐ Foster daughter	☐ Mother	☐ Significant other	☐ Wife
	☐ Foster son	☐ Mother-in-law	☐ Sister	

3. Client Information

First	Middle	Last	Suffix
Alias			

SSN	- -	**Gender**	☐ Male ☐ Female ☐ A gender other than singularly female or male (e.g., non-binary, genderfluid, agender, culturally specific gender. ☐ Transgender ☐ Questioning
SSN Data Quality	☐ Full Reported ☐ Partial/Approx. Reported ☐ Client doesn't know ☐ Client refused		
Date of Birth	Month Day Year	**Ethnicity**	☐ Non-Hispanic/Non-Latin (a) (o) (x) ☐ Hispanic/Latin (a) (o) (x) ☐ Client doesn't know ☐ Client refused
DOB Data Quality	☐ Full Reported ☐ Partial/Approx. Reported ☐ Client doesn't know ☐ Client refused		
Primary Race & Secondary Race	Pri Sec ☐ ☐ American Indian, Alaska Native, or Indigenous ☐ ☐ Asian, or Asian American ☐ ☐ Black, African American, orAfrican ☐ ☐ Native Hawaiian or Pacific Islander ☐ ☐ White ☐ ☐ Client doesn't know ☐ ☐ Client refused	**Disabling Condition?**	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Zip Code of Last Permanent Address		**Zip Data Quality**	☐ Full Reported ☐ Partial/Approx. Reported ☐ Client doesn't know ☐ Client refused

4. Monthly Income/Non-Cash Benefits/Health Insurance/Disabilities

Income from any source:	☐ Yes ☐ No (*If yes, Please record on HoH Intake.)*
Covered by Health Insurance:	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

Health Insurance Type:	☐ MEDICAID/MEDI-CAL	☐ MEDICARE	☐ State Children's Health Insurance Program	☐ VA Medical Services
	☐ Employer – Provided Health Insurance		☐ Health Insurance obtained through COBRA	☐ Private Pay Health Insurance
	☐ State Health Insurance for Adults		☐ Indian Health Services Program	☐ Other

Disability Type:	**Determination**	**If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?**
Alcohol Use Disorder	☐ Yes ☐ No	Start Date: ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Both Alcohol and Drug Use Disorder	☐ Yes ☐ No	Start Date: ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Chronic Health Condition	☐ Yes ☐ No	Start Date: ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Developmental	☐ Yes ☐ No	Start Date: ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Drug Abuse	☐ Yes ☐ No	Start Date: ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
HIV/AIDS	☐ Yes ☐ No	Start Date: ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Mental Health Disorder	☐ Yes ☐ No	Start Date: ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused
Physical	☐ Yes ☐ No	Start Date: ☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused

*Please make sure to get a RELEASE OF INFORMATION (ROI) signed for each additional adult Household member. *