HMIS Intake and Enrollment Form
Child-All Programs

Client ID: _____
Project Name: _____
Staff Name: _____

For persons entering HMIS project type: ***All HMIS projects*** ☐*Also for persons entering CES Enrollment*

Returning Clients: Where did you go/stay when you left the last time you were here?
_____

Identification-*All fields required unless otherwise noted*

First Name: _____ **Middle Name:** _____

Last Name: _____ **Suffix:** _____

Name Data Quality: Did the client provide their full name?

☐Full Name Reported ☐Partial, street name, or code name reported
☐Client doesn't know ☐Client prefers not to answer

Social Security Number (SSN): _____-_____-_____

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

Birth Date (DOB): _____/_____/_____

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

Name of Head of Household: _____

Relationship to Head of Household

☐Self ☐Son
☐Daughter ☐Dependent child
☐Spouse ☐Other Family Member
☐Other Non-Family Member

Basic Demographics-*All fields required unless otherwise noted*

Race and Ethnicity *(Check all that apply)*

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

Sex

☐Woman
☐Man
☐Client doesn't know
☐Client prefers not to answer

Mailing Address and Contact Information *(Includes, not limited to, service organizations, access centers, emergency shelter, transitional housing, client residence)*

Address: _____
City, State, Zip Code: _____
Email: _____
Main Phone: _____
Message Phone: _____

Project Start Date: _____/_____/_____ **CE Project Start Date:** _____/_____/_____

Health Insurance	
☐Yes (*Select source)* ☐No ☐Client doesn't know ☐Client prefers not to answer	
Health Insurance Sources *(Check all that apply)*	
☐Private Pay Health Insurance	☐Medicare
☐MEDICAID	☐Health Net (Medi-Cal)-Adults
☐Health Net (Medi-Cal)-Children	☐State Kaiser (Medi-Cal)-Adults
☐State Kaiser (Medi-Cal)-Children	☐Health Plan of San Joaquin (Medi-Cal)-Adults
☐Health Plan of San Joaquin (Medi-Cal)-Children	☐State Children's Health Insurance (Medi-Cal)
☐Veteran's Health Administration (VHA)	☐Employer Provided Health Insurance
☐Health Insurance obtained through COBRA	☐State Funded Insurance for Adults (Medi-Cal)
☐Indian Health Services Program (IHS)	☐Other: _____
Disabling Condition	
☐Yes ☐No ☐Client doesn't know ☐Client prefers not to answer	

Barriers-All programs except SSVF *(Check all that apply)*		
	Barrier Present	**Condition is indefinite**
☐Alcohol Disorder	☐Yes ☐No ☐Doesn't know ☐ Client prefers not to answer	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer
☐Chronic Health Condition	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer
☐Developmental Disability	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer	
☐Drug Use Disorder	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer
☐HIV/AIDS	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer	
☐Mental Health Disorder	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer
☐Physical Disability	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer	☐Yes ☐No ☐Doesn't know ☐Client prefers not to answer