Housing & Homeless Coalition
Of Central New York

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Emergency Shelter/ Street Outreach Intake Form (Children in Households)
(Please complete this form for ALL Children under 18 years of age)

Client Name: _____
Project Start Date: _____
SS#: _ _ _ - _ _ - _ _ _ _ **DOB**___/___/_____ **Zip Code of Last Permanent Address:** _____

Race: ____ American Indian/ Alaska Native
____ Asian
____ Black/ African American
____ Native Hawaiian/ Pacific Islander
____ White

Ethnicity: ____ Hispanic/ Latino
____ Non-Hispanic/ Latino

Relationship to Head of Household:
____ Self (Head of Household)
____ Head of Household's Child
____ Head of Household's Spouse/ Partner
____ Head of Household's Other Relative
____ Other: Non-Relative

Gender: ____ Female
____ Male
____ Trans Female (MTF or Male to Female)
____ Trans Male (FTM or Female to Male)
____ Gender Non-conforming (ie: not exclusively male or female)

Primary Language: ____Arabic ____Armenian ____Bangali ____Catonese ____Chinese ____English ____French ____French Creole ____German ____Greek ____Gujarati ____Hatian Creole ____Hebrew ____Hindi ____Hmong ____Italian ____Japanese ____Korean ____Mandarin ____Panjabi ____Persian ____Polish ____Portuguese ____Russian ____Spanish ____Tagalog ____Telugu ____Urdu ____Vietnamese ____Yiddish

Do you have Health Insurance/ Medical Assistance? ____Yes ____ No
Source of Health Insurance/ Medical Assistance:
_____ Medicaid _____ Medicare _____ State Children's Health Insurance Program
_____ Veteran's Administration (VA) Medical Services _____ Employer – Provided Health Insurance
_____ Health Insurance obtained through COBRA _____ State Health Insurance for Adults
_____ Indian Health Care _____ Other
Medicaid ID# _____
Medicaid Insurance Company: ____ Total Care ____ Blue Cross Blue Shield ____ Fidelis
____ United Healthcare ____ Molina Healthcare

Do you have a DISABILITY of long duration? ____Yes ____ No
If yes, do you have determination of Disability? ____Yes ____ No
If yes, are you currently receiving treatment for Disability? ____Yes ____ No

Disability Type:
____ Alcohol Abuse ONLY ____ BOTH Alcohol & Drug Abuse ____ Drug Abuse ONLY
____ Chronic Health Condition ____ Developmental ____ HIV/AIDS
____ Mental Health ____ Physical Health

Date of Engagement: ___/___/___ (Complete upon client entering Service Plan development or fully completed initial assessment)
Housing Move In Date: ___/___/___ (Complete if moving into PERMANENT HOUSING {RRH, PSH or OPH})