CHILD ASSESSMENT Client ID #: _____

Admin Only: ☐ HH ☐ SnC

☐Entry Date:_____ ☐Exit Date:_____ ☐Intake Date:_____

Individual's Name:_____ **HofH Name:** _____

Relationship to HofH:_____ **Social Security Number:**_____-_____-_____ **Program Type:**_____

Site:_____ **Unit #:**_____ **FSC:** _____

CLIENT PROFILE	RACE (choose all that apply)	CITIZENSHIP & LANGUAGE
Date of Birth: _____ **Age:** _____	☐White ☐Middle Eastern/ North African ☐Asian or Asian American ☐ Hispanic/Latin(x)(a)(o) ☐Native Hawaiian or Pacific Islander ☐Black, African American, or African ☐ American Indian, Alaskan Native or Indigenous **Tribe**:_____	☐Legal/U.S. Citizen ☐Ineligible non-resident ☐Eligible non-resident ☐ Always speaks English **Primary Language:** _____ **Preferred Language:** _____

GENDER (Choose all that apply):

☐Man
☐Woman
☐Culturally Specific Identity (e.g., Two-Spirit)
☐Transgender
☐Non-Binary
☐Questioning
☐Different Identity: _____
☐Prefers not to answer

DOCUMENTATION:

Client has an original social security card? ☐YES ☐NO
If **NO**, new card on order? ☐YES ☐NO
☐CM has confirmed SS card copy is on file

Client has a Certified Birth Certificate? ☐YES ☐NO
If **NO**, new Certificate on order? ☐YES ☐NO

PREGNANT:

☐ Yes
☐ No

When are you due?

_____

Barriers/Special Needs ☐ No Barriers

If client has one or more barriers …then for each barrier below check **Yes** or **No**

If, **YES**, answer the corresponding barrier questions.

☐ Y ☐ N **Substance Abuse**
If YES: ☐ Alcohol ☐ Drug ☐ Alcohol & Drug
Describe: _____
☐ Y ☐ N Receiving Services/Treatment?
☐ Y ☐ N Supporting Documents on File?

☐ Y ☐ N **Mental Health Problem**
Describe: _____
☐ Y ☐ N Receiving Services/Treatment?
☐ Y ☐ N Supporting Documents on File?

☐ Y ☐ N **Physical Disability**
Describe: _____
☐ Y ☐ N Receiving Services/Treatment?
☐ Y ☐ N Supporting Documents on File?

☐ Y ☐ N **Developmental Dis.**
Describe: _____
☐ Y ☐ N Receiving Services/Treatment?
☐ Y ☐ N Supporting Documents on File?

☐ Y ☐ N **Chronic Health Cond.**
Describe: _____
☐ Y ☐ N Receiving Services/Treatment?
☐ Y ☐ N Supporting Documents on File?

EDUCATION:

Currently Enrolled? Yes No

School Type? ☐ Public ☐Private/Parochial

School Name

School District

Did client have an IEP/504 in school? Yes No

Highest grade achieved in Nursery – 12th Grade

None	N-4th	5th or 6th	7th or 8th	9th
10th	11th	12th (No Diploma)	HS Graduate	GED

CLIENT HAS HEALTH INSURANCE:

Intake	YES NO	Medicare	Medicaid	Occupational	Other
Entry/Exit	YES NO	Medicare	Medicaid	Occupational	Other

Other:_____

If NO Current health insurance list last coverage…

Type: _____ End Date _____