HCHN Respite Program
Client Information Form

	Name		Date of Birth		
HCHN ID					
	Last	First	Month	Day	Year

Admission Date: _____

If client died, please provide date of death: _____

Race (check ALL that apply)
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Black/African American
- ☐ White
- ☐ Multi-racial (specify): _____ _____
- ☐ Other (specify): _____

AND of Hispanic Origin?
- ☐ Yes ☐ No
- ☐ Did not ask
- ☐ Client declined

Refugee/Immigrant:
- ☐ Yes
- ☐ No
- ☐ Did Not Ask
- ☐ Client Declined

If yes, Country of Origin:
_____

Language/Interpreter Services
Best served in language other than English?
- ☐ Yes
- ☐ No
- ☐ Did not ask
- ☐ Client declined

Gender
- ☐ Male ☐ MTF
- ☐ Female ☐ FTM

Social Unit
- ☐ Individual
- ☐ Family _____ #Adults _____ #Children
  - ☐ Parenting & 19 yrs or younger

Homeless Information
# of times Homeless
- ☐ First time
- ☐ 1 to 3 times
- ☐ More than 3 times
- ☐ Did Not Ask
- ☐ Client declined

How Long Homeless This Time
- ☐ Less than 1 year
- ☐ 1 to 3 years
- ☐ More than 3 years
- ☐ Did Not Ask
- ☐ Client declined

Veteran Status
- ☐ Yes
- ☐ Yes Vietnam
- ☐ No
- ☐ Did Not Ask
- ☐ Client Declined

SPECIAL NEEDS/DISABILITY--check all that apply

	No Problem Identified	Suspected Disability	Diagnosed Disability	Receives SSI/SSDI for disability
Developmental	☐	☐	☐	☐
Cognitive	☐	☐	☐	☐
Physical	☐	☐	☐	☐
HIV/AIDS	☐	☐	☐	☐
Psychiatric	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐
IV Drug Abuse	☐	☐	☐	☐
Other Drug Abuse	☐	☐	☐	☐
Drug Use	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐

FINANCIAL RESOURCES

AT ADMISSION	AT DISCHARGE	
☐	☐	No Resources
☐	☐	SSI
☐	☐	SSDI
☐	☐	SSA/Retired
☐	☐	GA
☐	☐	Food Stamps
☐	☐	VA Financial Benefits
☐	☐	Unemployment
☐	☐	Worker's Comp
☐	☐	Employed
☐	☐	Job Training
☐	☐	Other(specify): _____
☐	☐	Did not ask
☐	☐	Client declined

Gross Monthly Income

☐	☐	None
☐	☐	$1-150
☐	☐	$151-$250
☐	☐	$251-500
☐	☐	$501-$1000
☐	☐	$1001-1500
☐	☐	$1501-2000
☐	☐	$2001+

Medical Coverage/Health Insurance

☐	☐	No Insurance
☐	☐	Medicaid (GAX, HO, Exempt, CNR)
☐	☐	Medicare
☐	☐	Other Public Plan (BHP, GAU)
☐	☐	VA Medical Benefits
☐	☐	Private Insurance
☐	☐	Other(specify): _____
☐	☐	Did not ask
☐	☐	Client declined

Signature of person completing intake information: _____ Provider #: _____

Signature of person completing discharge information: _____ Provider #: _____