Kings/Tulare HMIS — COVID-19 Screening Form

1. Intake Summary

Program Name_____ **Client ID** (Computer Generated)_____

Assessment Date _____/_____/_____ **Intake Staff Name**_____

2. Client Demographics

First _____ **Middle**_____ **Last** _____ **Suffix**_____

Name Data Quality:

☐ Full name reported ☐ Partial, street name, or code name reported

☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected

SSN/Code:	**Date of Birth/Code:**	**Ethnicity:**	**Race:**
_____- ____- _____ ☐ Full SSN ☐ Approx/Partial SSN ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	_____/_____/_____ ☐ Full DOB ☐ Approx/Partial DOB **At a minimum, approximate year of birth is required.*	☐ Non-Hispanic/Non-Latin(a)(o)(x) ☐ Hispanic/Latin(a)(o)(x) ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ American Indian, Alaska Native, or Indigenous ☐ Asian or Asian American ☐ Black, African American, or African ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected
Gender	**Disabling Condition**	**Veteran Status**	**Relation to Head of Household**
☐ Female ☐ Male ☐ A gender that is not singularly 'Female' or 'Male' ☐ Transgender ☐ Questioning ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ No ☐ Yes ☐ Client Doesn't Know ☐ Client Refused ☐ Data Not Collected	☐ Self (head of household) ☐ Head of household's child ☐ Head of household's spouse/partner ☐ Head of household's other relation member (other relation to head of household) ☐ Other: non-relation member

3. Contact Information

Street Address	Email
City, State, Zip	Phone

4. Emergency Contact Information

Type/Description		Relationship	
☐ Emergency	☐ Primary Care Giver	☐ Self	☐ Guardian
☐ Relative	☐ Physician	☐ Spouse	☐ Parent
☐ Friend	☐ Mentor	☐ Dependent Child	☐ Other Family Member
☐ Guardian	☐ Other	☐ Daughter	☐ Other Non-Family Member
		☐ Son	☐ Ex-Spouse
Aware of Clients Situation: ☐ No ☐ Yes ☐ Unknown		☐ Grandparent	☐ Other Caretaker

Emergency Contact

Name_____ Home Phone_____
Address_____ Cell Phone_____
City_____State_____ZIP Code_____ Email_____

5. Screening Information

Current Temperature _____° **Location**(city client resides)_____

Symptoms		Existing Conditions	
☐ Fever	☐ Nasal Congestion	☐ Chronic Lung Disease	☐ Immunocompromised (including cancer treatment)
☐ Cough	☐ Loss of Smell	☐ Smoke	☐ Corticosteroids Prolonged Use
☐ Shortness of Breath	☐ Runny Nose	☐ Asthma	☐ Severe Obesity (BMI >40%)
☐ Tiredness	☐ Sore Throat	☐ Transplant Recipient	☐ Diabetes
☐ Aches and Pains	☐ Diarrhea	☐ Autoimmune Disease	☐ Dialysis for Kidney Disease
		☐ HIV/AIDS	☐ Serious Heart Condition
		☐ Liver Disease	

Height	**Known Exposure to COVID-19:**	**Previously Tested:**	**Prior Test Date**	**Prior Test Result:**
(feet): _____	☐ No ☐ Yes	☐ No ☐ Yes	**____/____/_____**	☐ Positive
(inches): _____				☐ Negative
Weight:_____lbs				☐ Unknown

Current Test Status	Test Result	
☐ Taken	☐ Positive	Isolation Date: _____/_____/_____
☐ Sent	☐ Negative	Hospitalization Date: _____/_____/_____
☐ Pending	☐ Unknown	Recovered Date: _____/_____/_____
☐ Returned		

Current Test Status	
☐ Asymptomatic Low Risk	☐ COVID-19 Exposed
☐ Asymptomatic High Risk	☐ COVID-19 Positive

6. Additional Information	
Additional Health Information	**Physician Information**
Health Insurance: ☐ No ☐ Yes	Doctor Name:_____
Insurance Type: ☐ Anthem ☐ Health Net ☐ Other	Doctor Phone:_____
Any Additional Health Concerns:	Remarks/Comments: