# Alaska BoS CE Intake Assessment - Household Members

**Project Entry Date (Use for Back-Date Mode in AKHMIS): ____/____/_____**

**Today's Date: _____/_____/_____ Staff who completed Intake: _____**

**Head of Household Name: _____ Client Phone Number: (_____)_____-_____**

**Client Name: _____ Relationship to HoH: _____**

**Does the client have a disabling condition?** ☐ Yes ☐ No

**Primary Alaska Regional Corporation**

☐ Not Affiliated

☐ Ahtna Corp.
☐ Aleut Corp.
☐ Arctic Slope Regional Corp.
☐ Bering Straits Native Corp.
☐ Bristol Bay Native Corp.
☐ Calista Corp.
☐ Chugach Alaska Corp.
☐ Cook Inlet Regional Corp.
☐ Doyon Limited Corp.
☐ Goldbelt
☐ Koniag Incorp.
☐ NANA Regional Corp.
☐ Sealaska

**Secondary Alaska Regional Corporation (if applicable):**

**Alaska Mental Health Trust (AMHT) Beneficiary** (Select an answer for each disability type.)

| Does the client have any of the following disabilities? | | | | | |
|---|---|---|---|---|---|
| | Alzheimer's Disease and Related Dementias | ☐ Yes | ☐ No | ☐ Client doesn't know | ☐ Client refused |
| | Chronic Alcoholism or other Substance Use Disorder | ☐ Yes | ☐ No | ☐ Client doesn't know | ☐ Client refused |
| | Intellectual or Developmental Disabilities | ☐ Yes | ☐ No | ☐ Client doesn't know | ☐ Client refused |
| | Mental Illness | ☐ Yes | ☐ No | ☐ Client doesn't know | ☐ Client refused |
| | Traumatic Brain Injuries | ☐ Yes | ☐ No | ☐ Client doesn't know | ☐ Client refused |

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