|  |  |
| --- | --- |
| **Agency:**  | **Project Entry Date:**  |
| **Project:**  | **Case Worker:**  |

**Add HMIS Family Member**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name Quality\*** |  **First Name\*:**   | **Middle:**  | **Last\***  |
| ☐ Full name ☐ Partial, street/code name ☐ Client refused ☐ Client doesn’t know ☐ Data Not Collected | **Birth Date\*:**  **Age**  |
| ☐ Full DOB ☐ Partial (MM/YY)  | ☐ Partial (DD/YY) ☐ Client Doesn’t Know  | ☐ Client Refused☐ Data Not Collected |
| **Gender\***☐ Male ☐ Female☐ Transgender Male to Female☐ Transgender Female to Male☐ Does not identify as male, female or transgendered ☐ Client doesn’t know☐ Client Refused☐ Data Not Collected | **Social Security#\***  |
| ☐ Full ☐ Partial | ☐ Client Doesn’t Know☐ Client Refused | ☐ Data Not Collected |
| **Primary Language\*** |
| ☐ Chinese ☐ Chuukese☐ English☐ Ilocano | ☐ Japanese ☐ Korean☐ Marshallese | ☐ Spanish ☐ Tagalog ☐ Vietnamese |
| **Ethnicity\* (Select One)**☐ Non-Hispanic or Latino☐ Hispanic or Latino | ☐ Client Doesn’t Know☐ Client Refused☐ Data Not Collected | Other  |
|   |
| **Citizenship Status** ☐ U.S. Citizen ☐ Eligible Non-Citizen ☐ Non-US Citizen COFA☐ U.S. National (American Samoa or Swains Island) | ☐ Ineligible Non-Citizen ☐ Undocumented ☐ Client Doesn’t Know☐ Client Refused☐ Data Not Collected |
| **Race\* (Multiple may be Selected)** |
| ☐ American Indian or Alaska Native ☐ Asian |
| ☐ Black/African American☐ Native Hawaiian/Other Pacific Islander |
| ☐ White☐ Client Doesn’t Know☐ Client Refused☐ Other☐ Data Not collected | **If Non-US Citizen COFA\***☐ Chuuk-Micronesia☐ Kosrae-Micronesia☐ Marshall Islands ☐ Palau  | ☐ Pohnpei-Micronesia☐ Yap-Micronesia☐ Client Doesn’t Know☐ Client Refused☐ Data Not Collected |
| **If Asian Chosen Above\***☐ Asian Indian☐ Chinese/Taiwanese | ☐ Filipino☐ Japanese☐ Korean | ☐ Vietnamese☐ Other Asian  |
| **If Native Hawaiian/Other Pacific Islander chosen above\*** |
| ☐ Hawaiian☐ Guamanian/Chamorro | ☐ Marshallese☐ Micronesian | ☐ Samoan | ☐ Tongan |
| ☐ Other Pacific Islander  |
| **Relations to HOH\*** | ☐ Child | ☐ Step-child  | ☐ Foster-child | ☐ Other Relative | ☐ Other Non-Relative  |

**Other Information - CONSENT**

**Was Consent given to share data? :** ☐Yes ☐No **(Use HMIS Consent Form)**

**Date of Consent:**

**Hawaii Enrollment Add/Edit**

|  |  |
| --- | --- |
| **Enrollment Entry Date\*:**  | **Program\*:**   |
|  | **Family or Individual:** ☐ family  |

**HUD Program Data - Child**

**Health Insurance\*** *Are you covered by health insurance?*

 ☐ No ☐ Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

**Disabling Condition**

**Substance Abuse\*** (If “NO” selected, skip to Mental Health)

 ☐ No ☐ Alcohol Abuse ☐ Drug Abuse

 ☐ Both Alcohol and Drug Abuse ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

1. **Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?**

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

1. **Documentation of the disability and severity on File:** ☐ No ☐Yes
2. **Currently receiving services/treatment for this condition?**

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

**Mental Health Problem\*** (If “NO” selected, skip to Developmental Disability)

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

1. **Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?**

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

1. **Documentation of the disability and severity on File:** ☐ No ☐Yes
2. **Currently receiving services/treatment for this condition?**

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

**Developmental Disability\*** (If “NO” selected, skip to Chronic Health Condition)

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

1. **Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?**

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

1. **Documentation of the disability and severity on File:** ☐ No ☐Yes
2. **Currently receiving services/treatment for this condition?**

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

**Chronic Health Condition\*** (If “NO” selected, skip to HIV / AIDS)

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

1. **Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?**

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

1. **Documentation of the disability and severity on File:** ☐ No ☐Yes
2. **Currently receiving services/treatment for this condition?**

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

**HIV / AIDS\*** (If “NO” selected, skip to Physical Disability)

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

1. **Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?**

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

1. **Documentation of the disability and severity on File:** ☐ No ☐Yes
2. **Currently receiving services/treatment for this condition?**

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

**HUD Program Data – Child (Continued)**

**Physical Disability\*** (If “NO” selected, skip to Health Insurance Assessment)

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

1. **Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?**

 ☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

1. **Documentation of the disability and severity on File:** ☐No ☐Yes
2. **Currently receiving services/treatment for this condition?**

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

**Health Insurance Assessment** (*if yes to health insurance)*

|  |  |
| --- | --- |
| ☐ Medicaid | ☐ Health Insurance through Cobra |
| ☐ Medicare | ☐ State Health Insurance for Adults |
| ☐ State Children’s Health Insurance | ☐ Private Insurance |
| ☐ VA-Veteran’s Administration Medical Services | ☐ Indian Health Services Program |
| ☐ Employer-Provided Health Insurance | ☐ Other  |