



A Tradition of Stewardship
A Commitment to Service

Napa County Continuum of Care

Standard HMIS Child Client Enrollment

Program Name: _____ Case Worker/Intake Person: _____ Program Start Date: _____

CLIENT ENROLLMENT

Separate client enrollments should be completed for each client who is **under** the age of 18 unless they are the Head of Household. **Separate client enrollments must be completed for adults as well, but please be sure to use the Standard HMIS Adult Client Enrollment form.**

1) Client Name	First	Last																				
Relationship to Head of Household	<input type="checkbox"/> Self (Head of Household) <input type="checkbox"/> Head of Household's child <input type="checkbox"/> Head of Household's spouse or partner <input type="checkbox"/> Head of Household's other relation member (other relation to Head of Household) <input type="checkbox"/> Other: non-relation member																					
2) Date of Program Enrollment	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px;"> </td> <td style="width: 25px;"> </td> <td style="width: 25px;">/</td> <td style="width: 25px;"> </td> <td style="width: 25px;"> </td> <td style="width: 25px;">/</td> <td style="width: 25px;"> </td> <td style="width: 25px;"> </td> <td style="width: 25px;"> </td> <td style="width: 25px;"> </td> </tr> <tr> <td>Month</td> <td>Day</td> <td></td> <td>Year</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>				/			/					Month	Day		Year						
		/			/																	
Month	Day		Year																			
<p><i>The date the client started being helped by the project (program); also called the project start date.</i></p>																						

DISABLING CONDITIONS: A Disabling Condition is a health condition that interferes with getting and/or keeping stable housing.

1) Does the client currently have a disabling condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
<p><i>A Disabling Condition is a health condition that interferes with getting and/or keeping stable housing.</i></p> <p><i>This question is used with other information to determine if the client meets criteria for chronic homelessness.</i></p> <p>All questions in this section MUST be answered even if the answer is "no" to this question.</p>		
2) Does the client have a Physical Disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected

Client Name _____

Head of Household Name (if not Self) _____

<p>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
<p>3) Does the client have a Developmental Disability?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
<p>4) Does the client have a Chronic Health Condition?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
<p>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
<p>5) Does the client have HIV – AIDS?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
<p>6) Does the client have a Mental Health Disorder?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
<p>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
<p>7) Does the client have any Substance Use Disorder?</p>	<input type="checkbox"/> No <input type="checkbox"/> Alcohol use disorder <input type="checkbox"/> Drug use disorder <input type="checkbox"/> Both Alcohol & Drug Abuse Use Disorders	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
<p>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected

HEALTH INSURANCE

<p>Currently covered by health insurance? <i>Is the client currently covered by health insurance?</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
<p>If Yes, type(s) of insurance(s): <i>If the client is currently covered by multiple health insurances please select all that apply.</i></p>	<input type="checkbox"/> Medicaid (same as Medi-Cal) <input type="checkbox"/> Medicare <input type="checkbox"/> State Children's Health Insurance (CHIP) Program <input type="checkbox"/> Veteran's Health Administration (VHA)

Client Name _____

Head of Household Name (if not Self) _____

- Employer-Provided Health Insurance
 - Health Insurance Obtained Through COBRA
 - Private Pay Health Insurance
 - State Health Insurance for Adults
 - Indian Health Services Program
 - Other Health Insurance
- If Other Specify: _____

Client Name _____

Head of Household Name (if not Self) _____