



Napa County Continuum of Care

HMIS Adult Client Enrollment
Abode Services Agency –
HDAP Program



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

CLIENT ENROLLMENT

Separate client enrollments should be completed for each client who is **over** the age of 17 or the Head of Household. **Separate client enrollments must be completed for children as well, but please be sure to use the Standard HMIS Child 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 <i>The date the client started being helped by the project (program); also called the project start date.</i>	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;">/</td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;">/</td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> </tr> <tr> <td colspan="3">Month</td> <td colspan="3">Day</td> <td colspan="4">Year</td> </tr> </table>			/			/					Month			Day			Year				
		/			/																	
Month			Day			Year																
3) Translation Assistance Needed [Head of Household only] <i>Does the client need access to translation services?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected																					
If Yes, Preferred Language(s): <i>If the client needs access to translation services, please select their preferred language(s).</i>	<input type="checkbox"/> American Sign Language <input type="checkbox"/> Arabic <input type="checkbox"/> Armenian <input type="checkbox"/> Black American Sign Lanugage <input type="checkbox"/> Cantonese <input type="checkbox"/> Cape Verdean Creole <input type="checkbox"/> Chinese <input type="checkbox"/> English <input type="checkbox"/> Farsi	<input type="checkbox"/> Mixteco <input type="checkbox"/> Persian <input type="checkbox"/> Portuguese <input type="checkbox"/> Punjabi <input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Tagalog <input type="checkbox"/> Taiwanese <input type="checkbox"/> Thai																				

Client Name _____

Head of Household Name (if not Self) _____

	<input type="checkbox"/> Fijian <input type="checkbox"/> Filipino <input type="checkbox"/> French <input type="checkbox"/> Greek <input type="checkbox"/> Haitian <input type="checkbox"/> Hindi <input type="checkbox"/> Hmong <input type="checkbox"/> Korean <input type="checkbox"/> Mandarin	<input type="checkbox"/> Ukrainian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Different Preferred Language, please specify: <hr/> <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected										
<p>PRIOR LIVING SITUATION – ANSWER <u>ONLY ONE FULL SECTION</u>: A or B or C [Head of Household and Adults only]</p>												
<p>Type of Residence <u>A – Homeless Living Situations</u></p> <p><i>What was the client's living situation the night before enrolling in the project?</i></p> <p><i>Ask the client "where did you stay or sleep last night"?</i></p>	<input type="checkbox"/> Place not meant for human habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport/or anywhere outside) <input type="checkbox"/> Emergency Shelter, including hotel or motel paid for with emergency shelter voucher, or Host Home shelter <input type="checkbox"/> Safe Haven											
<p>Length of Stay in Prior Living Situation</p>	<input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> One month or more, but less than 90 days	<input type="checkbox"/> 90 days or more, but less than one year <input type="checkbox"/> One year or longer <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected										
<p>Approximate date <u>this episode</u> of homelessness started:</p> <p><i>When was the date the current homeless situation began?</i></p> <p><i>A break in homelessness is defined as being in any permanent or temporary housing situation for 7 consecutive nights or more, or spending 90 days or more in an institution (i.e., jail, substance abuse or mental health treatment facility, hospital, or other similar facility).</i></p>	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;">/</td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;">/</td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> </tr> </table>			/			/					
		/			/							
<p>Number of <i>times</i> the client has been on the streets or in Emergency Shelter in the <u>last three years</u></p>	<input type="checkbox"/> One Time <input type="checkbox"/> Two Times <input type="checkbox"/> Three Times	<input type="checkbox"/> Four or more times <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer										

Client Name _____

Head of Household Name (if not Self) _____

		<input type="checkbox"/> Data Not Collected										
<p>Total number of <i>months</i> client has been homeless on the streets or in Emergency Shelter in the <u>last three years</u></p>	<input type="checkbox"/> One month (this time is the first month) <input type="checkbox"/> 2 months <input type="checkbox"/> 7 months <input type="checkbox"/> 3 months <input type="checkbox"/> 8 months <input type="checkbox"/> 4 months <input type="checkbox"/> 9 months <input type="checkbox"/> 5 months <input type="checkbox"/> 10 months <input type="checkbox"/> 6 months <input type="checkbox"/> 11 months	<input type="checkbox"/> 12 months <input type="checkbox"/> More than 12 months <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected										
<p>Type of Residence <u>B – Institutional Living Situations</u></p> <p><i>What was the client's living situation the night before enrolling in the project?</i></p> <p><i>Ask the client "where did you stay or sleep last night"?</i></p>	<input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non—psychiatric medical facility <input type="checkbox"/> Jail, prison, or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center											
<p>Length of Stay in Prior Living Situation</p>	<input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> One month or more, but less than 90 days	<input type="checkbox"/> 90 days or more, but less than one year <input type="checkbox"/> One year or longer <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected										
<p>Was the length of stay less than 90 days?</p> <p><i>If the response is "No," STOP here and skip down to the Disability section.</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No											
<p>If the response is "Yes", did the client stay on the streets or in emergency shelter the night before going to the institutional situation?</p> <p><i>If the response is "No," STOP here and skip down to the Disability section.</i></p> <p><i>If the response is "Yes," please answer the following questions below:</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No											
<p>Approximate date <u>this episode of homelessness started</u>:</p> <p><i>When was the date the current homeless situation began?</i></p> <p><i>A break in homelessness is defined as being in any permanent or temporary housing situation for 7 consecutive nights or more, or spending 90 days or more in an institution (i.e., jail,</i></p>	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px; text-align: center;">/</td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px; text-align: center;">/</td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> <td style="width: 20px;"></td> </tr> </table>			/			/					
		/			/							

Client Name _____

Head of Household Name (if not Self) _____

<p><i>substance abuse or mental health treatment facility, hospital, or other similar facility).</i></p>		
<p>Number of <i>times</i> the client has been on the streets or in Emergency Shelter in the <u>last three years</u></p>	<p><input type="checkbox"/> One Time <input type="checkbox"/> Two Times <input type="checkbox"/> Three Times</p>	<p><input type="checkbox"/> Four or more times <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected</p>
<p>Total number of <i>months</i> client has been homeless on the streets or in Emergency Shelter in the <u>last three years</u></p>	<p><input type="checkbox"/> One month (this time is the first month) <input type="checkbox"/> 2 months <input type="checkbox"/> 7 months <input type="checkbox"/> 3 months <input type="checkbox"/> 8 months <input type="checkbox"/> 4 months <input type="checkbox"/> 9 months <input type="checkbox"/> 5 months <input type="checkbox"/> 10 months <input type="checkbox"/> 6 months <input type="checkbox"/> 11 months</p>	<p><input type="checkbox"/> 12 months <input type="checkbox"/> More than 12 months <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected</p>
<p>Type of Residence <u>C – Transitional OR Permanent Housing Living Situations</u></p> <p><i>What was the client's living situation the night before enrolling in the project?</i></p> <p><i>Ask the client "where did you stay or sleep last night"?</i></p>	<p>Temporary Housing Situations</p> <p><input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Staying or living in a friend's room, apartment, or house <input type="checkbox"/> Staying or living in a family member's room, apartment, or house</p> <p>Permanent Housing Situations</p> <p><input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy</p>	<p>Other</p> <p><input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected</p>
<p>Rental Subsidy Type: <i>If "Rental by client, with ongoing housing subsidy" is selected, please select the type of housing subsidy in use.</i></p>	<p><input type="checkbox"/> GPD TIP housing subsidy <input type="checkbox"/> VASH housing subsidy <input type="checkbox"/> RRRH or equivalent subsidy <input type="checkbox"/> HCV voucher (tenant or project based) (not dedicated) <input type="checkbox"/> Public housing unit <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Emergency Housing Voucher (EHV) <input type="checkbox"/> Family Unification Program Voucher (FUP) <input type="checkbox"/> Foster Youth to Independence Initiative (FYI) <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Other permanent housing dedicated for formerly homeless persons</p>	

Client Name _____

Head of Household Name (if not Self) _____

<p>Length of Stay in Prior Living Situation</p>	<input type="checkbox"/> One night or less <input type="checkbox"/> Two to six nights <input type="checkbox"/> One week or more, but less than one month <input type="checkbox"/> One month or more, but less than 90 days	<input type="checkbox"/> 90 days or more, but less than one year <input type="checkbox"/> One year or longer <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected										
<p>Was the length of stay less than 7 nights?</p> <p><i>If the response is "No," STOP here and skip down to the Disability section.</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No											
<p>If the response is "Yes", did the client stay on the streets or in emergency shelter the night before going to the transitional or permanent placement?</p> <p><i>If the response is "No," STOP here and skip down to the Disability section.</i></p> <p><i>If the response is "Yes," please answer the following questions below:</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No											
<p>Approximate date <u>this episode</u> of homelessness started:</p> <p><i>When was the date the current homeless situation began?</i></p> <p><i>A break in homelessness is defined as being in any permanent or temporary housing situation for 7 consecutive nights or more, or spending 90 days or more in an institution (i.e., jail, substance abuse or mental health treatment facility, hospital, or other similar facility).</i></p>	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;">/</td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;">/</td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> <td style="width: 20px;"> </td> </tr> </table>			/			/					
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<p>Number of <i>times</i> the client has been on the streets or in Emergency Shelter in the <u>last three years</u></p>	<input type="checkbox"/> One Time <input type="checkbox"/> Two Times <input type="checkbox"/> Three Times	<input type="checkbox"/> Four or more times <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected										
<p>Total number of <i>months</i> client has been homeless on the streets or in Emergency Shelter in the <u>last three years</u></p>	<input type="checkbox"/> One month (this time is the first month) <input type="checkbox"/> 2 months <input type="checkbox"/> 7 months <input type="checkbox"/> 3 months <input type="checkbox"/> 8 months <input type="checkbox"/> 4 months <input type="checkbox"/> 9 months	<input type="checkbox"/> 12 months <input type="checkbox"/> More than 12 months <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) _____

	<input type="checkbox"/> 5 months <input type="checkbox"/> 10 months <input type="checkbox"/> 6 months <input type="checkbox"/> 11 months	
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? <i>A Disabling Condition is a health condition that interferes with getting and/or keeping stable housing.</i> <i>This question is used with other information to determine if the client meets criteria for chronic homelessness.</i> All questions in this section MUST be answered even if the answer is "no" to this question.	<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
2) Does the client have a Physical Disability? If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?	<input type="checkbox"/> Yes <input type="checkbox"/> No <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 <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
3) Does the client have a Developmental 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
4) Does the client have a Chronic Health Condition? If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?	<input type="checkbox"/> Yes <input type="checkbox"/> No <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 <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
5) Does the client have HIV – AIDS?	<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
6) Does the client have a Mental Health Disorder?	<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>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

DOMESTIC VIOLENCE [Head of Household and Adults only]

<p>1) Survivor of Domestic Violence</p> <p><i>Ask the client "Have you ever experienced any domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions against you or a member of your family, including a child, that has happened in the place you were living?"</i></p> <p>If the answer is "no", skip to "Monthly Income – Cash Benefits" section.</p> <p>If the answer is "yes", COMPLETE questions 2 and 3.</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>2) Most Recent Occurrence</p> <p><i>Ask the client "How long ago was your most recent experience of domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions?"</i></p>	<input type="checkbox"/> Within the past three months <input type="checkbox"/> Three to six months ago (excluding six months exactly) <input type="checkbox"/> Six months to one year ago (excluding one year exactly) <input type="checkbox"/> One year ago or more <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected
<p>3) Current Status</p> <p><i>Ask the client "Are you currently fleeing, or attempting to flee, the domestic violence situation, or are you afraid to return to the place you are living?"</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

MONTHLY INCOME – CASH BENEFITS [Head of Household and Adults only]

<p>Current income from any source?</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
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Client Name _____

Head of Household Name (if not Self) _____

<p><i>Is the client currently receiving any income from any source?</i></p> <p>Specify the type(s) and amount(s) of income the client currently receives.</p> <p><i>Only regular, recurrent sources that are current today should be included. Income received for a minor (under 18 years old) member of the household (e.g., SSI) should be recorded with the HoH's information.</i></p> <p><i>DO NOT include income received by other adults (18 years and older) in the household; record their income on their Enrollment form.</i></p>	<div style="background-color: #f0f0f0; padding: 5px;"> <input type="checkbox"/> Earned Income \$ _____ <input type="checkbox"/> Unemployment Insurance \$ _____ <input type="checkbox"/> Supplemental Security Income SSI \$ _____ <input type="checkbox"/> Social Security Disability Insurance SSDI \$ _____ <input type="checkbox"/> VA Service-Connected Disability Pension \$ _____ <input type="checkbox"/> VA Non-service connect disability pension \$ _____ <input type="checkbox"/> Private Disability Insurance \$ _____ <input type="checkbox"/> Worker's Compensation \$ _____ <input type="checkbox"/> Temporary Assistance for Needy Families TANF/CalWORKs \$ _____ <input type="checkbox"/> General Assistance (GA) \$ _____ <input type="checkbox"/> Retirement income from Social Security \$ _____ <input type="checkbox"/> Pension or Retirement Income from a Former Job \$ _____ <input type="checkbox"/> Child Support \$ _____ <input type="checkbox"/> Alimony and Other Spousal Support \$ _____ <input type="checkbox"/> Other Cash Income \$ _____ If Other Specify: _____ </div>
<p>Total Monthly Cash Income for Individual</p>	<p>TOTAL: \$ _____</p>

NON-CASH BENEFITS [Head of Household and Adults only]

<p>Currently receiving Non-Cash Benefits?</p> <p><i>Is the client currently receiving one of the non-cash benefits listed below?</i></p> <p>If Yes, indicate all the non-cash benefits the client is receiving:</p> <p><i>Only regular, recurrent sources that are current today should be included. Record non-cash benefits received by a minor member (under 18 years of age) of the household under the HoH's information.</i></p> <p><i>DO NOT include benefits received by other adults (18 years and older) in the household; record their benefits on their Enrollment form.</i></p>	<div style="background-color: #f0f0f0; padding: 5px;"> <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 </div> <div style="background-color: #f0f0f0; padding: 5px;"> <input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP)/Cal Fresh <input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) <input type="checkbox"/> TANF/CALWORKS Childcare Services <input type="checkbox"/> TANF/CALWORKS Transportation Services <input type="checkbox"/> Other TANF/CALWORKS-Funded Services <input type="checkbox"/> Other Non-Cash Benefit If Other Specify: _____ </div>
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Client Name _____

Head of Household Name (if not Self) _____

HEALTH INSURANCE	
<p>Currently covered by health insurance? <i>Is the client currently covered by health insurance?</i></p> <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>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer</p> <p><input type="checkbox"/> Data Not Collected</p> <hr/> <p><input type="checkbox"/> Medicaid (same as Medi-Cal)</p> <p><input type="checkbox"/> Medicare</p> <p><input type="checkbox"/> State Children's Health Insurance (CHIP) Program</p> <p><input type="checkbox"/> Veteran's Health Administration (VHA)</p> <p><input type="checkbox"/> Employer-Provided Health Insurance</p> <p><input type="checkbox"/> Health Insurance Obtained Through COBRA</p> <p><input type="checkbox"/> Private Pay Health Insurance</p> <p><input type="checkbox"/> State Health Insurance for Adults</p> <p><input type="checkbox"/> Indian Health Services Program</p> <p><input type="checkbox"/> Other Health Insurance</p> <p>If Other Specify: _____</p>
HDAP Required Questions [Head of Household and Adults only]	
At approval, sex	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender: Male to Female <input type="checkbox"/> Transgender: Female to Male <input type="checkbox"/> Nonbinary (neither Male nor Female)
At approval, gender identity	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender: Male to Female <input type="checkbox"/> Transgender: Female to Male <input type="checkbox"/> Nonbinary (neither Male nor Female) <input type="checkbox"/> Another gender identity <input type="checkbox"/> Decline to state
Sexual Orientation	<input type="checkbox"/> Straight or Heterosexual <input type="checkbox"/> Gay or Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Queer <input type="checkbox"/> Another Sexual Orientation <input type="checkbox"/> Unknown <input type="checkbox"/> Decline to state

Client Name _____

Head of Household Name (if not Self) _____

<p>At approval, which HDAP target population(s) is the participant a member of?</p> <p><i>You may select multiple populations per participant</i></p>	<ul style="list-style-type: none"><input type="checkbox"/> General Assistance/General Relief<input type="checkbox"/> CalWORKs<input type="checkbox"/> Diverted from Jail/Prison<input type="checkbox"/> Low Income Veterans<input type="checkbox"/> Discharged from Institution<input type="checkbox"/> Low income/No income (none of the above)
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Client Name _____

Head of Household Name (if not Self) _____