HMIS # _____

Staff Name _____

Date Form Completed / /

Santa Cruz County HMIS – HOPWA Child Enrollment

The service provider should complete this form while interviewing a child household member *as long as they are not the Head of Household*. ***A separate HOPWA Adult Enrollment Form must be completed for each adult member of the household. A separate HOPWA Enrollment Form must be completed for each child member of the household (non-Head of Household). A separate Enrollment Form must be completed for adult household members as well, but please be sure to use the HOPWA Adult Enrollment Form.***

1) Client Name	**First**	**Last**
Relationship to HoH (HUD) *Single individuals are also heads of household (HoH). In multiple person households one person must be designated head of household*	❑ Self (HoH) ❑ Child of HoH ❑ Spouse/partner of HoH ❑ Relative member of household ❑ Non-relative member of household	
Relationship to HoH – Additional Detail	❑ Self ❑ Husband/Wife ❑ Son/Daughter ❑ Father/Mother ❑ Sister/Brother ❑ Roommate ❑ Grandchild	❑ Aunt/Uncle ❑ Niece/Nephew ❑ Grandparent ❑ Significant Other ❑ Domestic Partner ❑ Other ❑ Stepdaughter/Stepson
2) Date of Program Enrollment *The date the client started being helped by the project (program); also called the project start date.*	/ / Month Day Year	

Client Name _____

Head of Household Name (if not Self) _____

Disabling Conditions (All Responses required)

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? *A Disabling Condition is a health condition that interferes with getting and/or keeping stable housing.* *This question is used with other information to determine if the client meets criteria for chronic homelessness.* ***All questions in this section MUST be answered even if the answer is "no" to this question.***	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer
2) Does the client have a Physical Disability?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer
If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer
3) Does the client have a Developmental Disability?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer
4) Does the client have a Chronic Health Condition?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer
If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer
5) Does the client have HIV – AIDS? *If **Yes**, please be sure to answer the required HIV/AIDS questions below.*	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer

Client Name _____

Head of Household Name (if not Self) _____

6) Does the client have a Mental Health Disorder?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer
If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer
7) Does the client have any Substance Use Disorder?	❑ No ❑ Alcohol use disorder ❑ Drug use disorder ❑ Both Alcohol & Drug Abuse Use Disorders	❑ Client doesn't know ❑ Client prefers not to answer
If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer

Health Insurance

Currently covered by health insurance? *Is the client currently covered by health insurance?*	❑ Yes ❑ No ❑ Client doesn't know ❑ Client prefers not to answer
If Yes, type(s) of insurance(s) and reason(s) not covered: *If the client is currently covered by multiple health insurances please select all that apply.*	❑ Medicaid (same as Medi-Cal) ❑ Applied; Decision Pending ❑ Applied; Client Not Eligible ❑ Client Did Not Apply ❑ Insurance Type N/A for this Client ❑ Client doesn't know ❑ Client prefers not to answer
	❑ Medicare ❑ Applied; Decision Pending ❑ Applied; Client Not Eligible ❑ Client Did Not Apply ❑ Insurance Type N/A for this Client ❑ Client doesn't know ❑ Client prefers not to answer

Client Name _____

Head of Household Name (if not Self) _____

❑ State Children's Health Insurance (CHIP) Program

- ❑ Applied; Decision Pending
- ❑ Applied; Client Not Eligible
- ❑ Client Did Not Apply
- ❑ Insurance Type N/A for this Client
- ❑ Client doesn't know
- ❑ Client prefers not to answer

❑ Veteran's Health Administration (VHA)

- ❑ Applied; Decision Pending
- ❑ Applied; Client Not Eligible
- ❑ Client Did Not Apply
- ❑ Insurance Type N/A for this Client
- ❑ Client doesn't know
- ❑ Client prefers not to answer

❑ Employer-Provided Health Insurance

- ❑ Applied; Decision Pending
- ❑ Applied; Client Not Eligible
- ❑ Client Did Not Apply
- ❑ Insurance Type N/A for this Client
- ❑ Client doesn't know
- ❑ Client prefers not to answer

❑ Health Insurance Obtained Through COBRA

- ❑ Applied; Decision Pending
- ❑ Applied; Client Not Eligible
- ❑ Client Did Not Apply
- ❑ Insurance Type N/A for this Client
- ❑ Client doesn't know
- ❑ Client prefers not to answer

❑ Private Pay Health Insurance

- ❑ Applied; Decision Pending
- ❑ Applied; Client Not Eligible
- ❑ Client Did Not Apply
- ❑ Insurance Type N/A for this Client
- ❑ Client doesn't know

Client Name _____

Head of Household Name (if not Self) _____

	❑ Client prefers not to answer
	❑ State Health Insurance for Adults ❑ Applied; Decision Pending ❑ Applied; Client Not Eligible ❑ Client Did Not Apply ❑ Insurance Type N/A for this Client ❑ Client doesn't know ❑ Client prefers not to answer
	❑ Indian Health Services Program ❑ Applied; Decision Pending ❑ Applied; Client Not Eligible ❑ Client Did Not Apply ❑ Insurance Type N/A for this Client ❑ Client doesn't know ❑ Client prefers not to answer
	❑ Other Health Insurance If Other Specify: _____

Medical Assistance [All Household Members with HIV/AIDS]

Is the client receiving AIDS Drug Assistance Program (ADAP)?	❑ No ❑ Yes ❑ Client doesn't know ❑ Client prefers not to answer
If No for "Receiving AIDS Drug Assistance Program (ADAP)," please select the appropriate reason:	❑ Applied; decision pending ❑ Applied; client not eligible ❑ Client did not apply ❑ Insurance type N/A for this client ❑ Client doesn't know ❑ Client prefers not to answer

Client Name _____

Head of Household Name (if not Self) _____

Is the client receiving AIDS Drug Assistance Program (ADAP)?	❑ No ❑ Yes ❑ Client doesn't know ❑ Client prefers not to answer
If No for "Receiving AIDS Drug Assistance Program (ADAP)," please select the appropriate reason:	❑ Applied; decision pending ❑ Applied; client not eligible ❑ Client did not apply ❑ Insurance type N/A for this client ❑ Client doesn't know ❑ Client prefers not to answer

T-cell (CD4) and Viral Load [All Household Members with HIV/AIDS]

T-Cell (CD4) Count Available?	❑ No ❑ Yes ❑ Client doesn't know ❑ Client prefers not to answer
If Yes to "T-Cell (CD4) Count Available," then please collect the T-cell Count number: *Integer between 0-1500*	
If a number is entered in the T-Cell (CD4) count, then how was the information obtained?	❑ Medical Report ❑ Client Report ❑ Other
Viral Load Information Available?	❑ Not Available ❑ Available ❑ Undetectable ❑ Client doesn't know ❑ Client prefers not to answer
If "Viral Load Information Available," then please collect the Viral Load Count: *Integer between 0-999999*	
If a number is entered in the Viral Load count, then how was the information obtained?	❑ Medical Report ❑ Client Report ❑ Other

Prescribed Anti-Retroviral [All Household Members with HIV/AIDS]

Has the participant been prescribed anti-retroviral drugs?	❑ No ❑ Yes ❑ Client doesn't know ❑ Client prefers not to answer

Client Name _____

Head of Household Name (if not Self) _____