

HMIS # _____

Staff Name _____

Date Form Completed ____/____/____

Santa Cruz County HMIS – Standard Child Enrollment

The service provider should complete this form while interviewing a child household member. 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 HoH (HUD) <i>Single individuals are also heads of household (HoH). In multiple person households one person must be designated head of household</i>	<input type="checkbox"/> Self (HoH) <input type="checkbox"/> Child of HoH <input type="checkbox"/> Spouse/partner of HoH <input type="checkbox"/> Relative member of household <input type="checkbox"/> Non-relative member of household																					
Relationship to HoH – Additional Detail	<input type="checkbox"/> Self <input type="checkbox"/> Husband/Wife <input type="checkbox"/> Son/Daughter <input type="checkbox"/> Father/Mother <input type="checkbox"/> Sister/Brother <input type="checkbox"/> Roommate <input type="checkbox"/> Grandchild <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Niece/Nephew <input type="checkbox"/> Grandparent <input type="checkbox"/> Significant Other <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other <input type="checkbox"/> Stepdaughter/Stepson																					
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"> <tr> <td></td><td></td><td>/</td><td></td><td></td><td>/</td><td></td><td></td><td></td><td></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																

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.

<p>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></p> <p><i>This question is used with other information to determine if the client meets criteria for chronic homelessness.</i></p> <p><i>All questions in this section MUST be answered even if the answer is "no" to this question.</i></p>	<div> <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know </div> <div> <input type="checkbox"/> No <input type="checkbox"/> Client prefers not to answer </div>
<p>2) Does the client have a Physical Disability?</p> <p><i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i></p>	<div> <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know </div> <div> <input type="checkbox"/> No <input type="checkbox"/> Client prefers not to answer </div>
<p>3) Does the client have a Developmental Disability?</p>	<div> <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know </div> <div> <input type="checkbox"/> No <input type="checkbox"/> Client prefers not to answer </div>
<p>4) Does the client have a Chronic Health Condition?</p> <p><i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i></p>	<div> <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know </div> <div> <input type="checkbox"/> No <input type="checkbox"/> Client prefers not to answer </div>
<p>5) Does the client have HIV – AIDS?</p>	<div> <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know </div> <div> <input type="checkbox"/> No <input type="checkbox"/> Client prefers not to answer </div>
<p>6) Does the client have a Mental Health Disorder?</p> <p><i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i></p>	<div> <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know </div> <div> <input type="checkbox"/> No <input type="checkbox"/> Client prefers not to answer </div>
<p>7) Does the client have any Substance Use Disorder?</p> <p><i>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</i></p>	<div> <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know </div> <div> <input type="checkbox"/> Alcohol use disorder <input type="checkbox"/> Client prefers not to answer </div> <div> <input type="checkbox"/> Drug use disorder </div> <div> <input type="checkbox"/> Both Alcohol & Drug Abuse Use Disorders </div> <div> <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know </div> <div> <input type="checkbox"/> No <input type="checkbox"/> Client prefers not to answer </div>

Client Name _____

Head of Household Name (if not Self) _____

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):

If the client is currently covered by multiple health insurances please select all that apply.

- ☐ Medicaid (same as Medi-Cal)
 - ☐ Medicare
 - ☐ State Children's Health Insurance (CHIP) Program
 - ☐ Veteran's Health Administration (VHA)
 - ☐ 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) _____