HMIS # _____

Staff Name _____

Date Form Completed / /

Santa Cruz County HMIS – Standard Child Enrollment

The service provider should complete this form for every new child household member **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 (HoH) (HUD) *Single individuals are considered the head of their household. In households with more than one person, a single 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

Client Name _____

Head of Household Name (if not Self) _____

2) Project Start Date *The date the client enrolled in the program; also considered when the client started being helped by the project (program).*	/ / Month Day Year

Disabling Conditions (All Responses required)

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 the criteria for chronic homelessness.

1) Does the client currently have a disabling condition? *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 client answers "no" to the Disabling Condition. If the client answers "Yes" to any of the questions below, the answer to the Disabling Condition question must also be "Yes" if the condition is disabling.***	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer
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?*	❑ Yes ❑ No ❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer ❑ 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

Client Name _____

Head of Household Name (if not Self) _____

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?	❑ Yes ❑ No	❑ Client doesn't know ❑ Client prefers not to answer
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 a 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

Client Name _____

Head of Household Name (if not Self) _____

Health Insurance

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, select they client's type(s) of health insurance(s) coverage: *If the client is currently covered by multiple health insurances, select all that apply.*	❑ Medicaid (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: _____

Additional Client Information

What is the client's sex?	❑ Female ❑ Male	❑ Client doesn't know ❑ Client prefers not to answer ❑ Data not collected

Client Name _____

Head of Household Name (if not Self) _____