FL-507 Central Florida HMIS

# Additional Household Member (Minors) Data Collection Guide – ENTRY ASSESSMENT

**Agency/Program:** ____________________________________________ **Assessment Date:** ____________

*(Complete a separate intake form for each minor in the household).*

## CLIENT INFORMATION

**Enrollment CoC**: ___FL-507___

**Client Name**: First ______________________ Middle ______________________ Last _____________________

**Name Data Quality**

| ☐ Full Name Reported | ☐ Partial, Street, or Code Name Reported | ☐ Client Doesn't Know | ☐ Client Prefers Not to Answer |
|---|---|---|---|

**Social Security Number** ________ -_____ - ________

**Social Security Number Data Quality**

| ☐ Full SSN Reported | ☐ Approximate or Partial SSN Reported | ☐ Client Doesn't Know | ☐ Client Prefers Not to Answer |
|---|---|---|---|

**Relationship to Head of Household**

| ☐ Self | ☐ Head of household's spouse or partner | ☐ Other: non-relation member |
|---|---|---|
| ☐ Head of household's child | ☐ Head of household's other relation member | |

**Date of Birth** ________ / ________ / ____________

**Date of Birth Data Quality**

| ☐ Full DOB Reported | ☐ Approx./Partial DOB Reported | ☐ Client Doesn't Know | ☐ Client Prefers Not to Answer |
|---|---|---|---|

**Race and Ethnicity**

| ☐ American Indian, Alaska Native, or Indigenous | ☐ Middle Easter or North African | ☐ Client Prefers Not to Answer |
|---|---|---|
| ☐ Asian or Asian American | ☐ Native Hawaiian or Pacific Islander | ☐ Data Not Collected |
| ☐ Black, African American, or African | ☐ White | |
| ☐ Hispanic/Latina/e/o | ☐ Client Doesn't Know | |

**Additional Race & Ethnicity Detail:** ______________________________________________________________

**Gender** (Select as many as apply)

| ☐ Woman (Girl, if child) | ☐ Man (Boy, if child) | ☐ Culturally Specific Identity (e.g., Two-Spirit) | ☐ Transgender | |
|---|---|---|---|---|
| ☐ Non-Binary | ☐ Questioning | ☐ Different Identity | ☐ Client Doesn't Know | ☐ Client Prefers Not to Answer |

**If different identity, please specify:** ______________________________________________________________

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## HEALTH INSURANCE INFORMATION

**Is the client covered by Health Insurance?**

| ☐ Yes | ☐ No | ☐ Client Doesn't Know | ☐ Client Prefers to Not Answer |
|---|---|---|---|

*If yes, check all that apply:*

| ☐ Private | ☐ Military Insurance |
|---|---|
| ☐ Private -Employer | ☐ State Funded |
| ☐ Private - Individual | ☐ Combined Children's Health Insurance/Medicaid |
| ☐ Medicare | ☐ Indian Health Service (IHS) |
| ☐ Medicaid | ☐ Other Public |
| ☐ State Children's Health Insurance Program S - CHIP | ☐ Health Insurance Obtained through COBRA |

## DISABILITY INFORMATION

**Does the client have a Disabling Condition?**

| ☐ Yes | ☐ No | ☐ Client Doesn't Know | ☐ Client Prefers Not to Answer |
|---|---|---|---|

*If yes, check all that apply and indicate whether it is long-continued and indefinite duration and substantially impairs ability to live independently.*

| Disability Type | **Long-continued/indefinite duration?** |
|---|---|
| ☐ Alcohol Use Disorder | ☐ Yes ☐ No ☐ Client Prefers Not to Answer ☐ Client Doesn't Know |
| ☐ Chronic Health Condition | ☐ Yes ☐ No ☐ Client Prefers Not to Answer ☐ Client Doesn't Know |
| ☐ Developmental Disability | ☐ Yes ☐ No ☐ Client Prefers Not to Answer ☐ Client Doesn't Know |
| ☐ Drug Use Disorder | ☐ Yes ☐ No ☐ Client Prefers Not to Answer ☐ Client Doesn't Know |
| ☐ HIV/AIDS | ☐ Yes ☐ No ☐ Client Prefers Not to Answer ☐ Client Doesn't Know |
| ☐ Mental Health | ☐ Yes ☐ No ☐ Client Prefers Not to Answer ☐ Client Doesn't Know |
| ☐ Physical Disability | ☐ Yes ☐ No ☐ Client Prefers Not to Answer ☐ Client Doesn't Know |