HMIS Entry Assessment – for Dependent Children Under 18 **HMIS ID #: _____**

Client's Name:
(write in name and check 1 data quality option): _____

_____ Full name _____Partial, street or code name _____Client doesn't know _____Client prefers not to answer

Social Security Number (SSN) (write in SSN and check 1 data quality option): _____

_____Full SSN _____Approx. or partial SSN _____Client doesn't know _____Client prefers not to answer

If different from head of household: Project Start Date: _____/_____/_____
Project Name:

Household Relationship e.g. "Son" (write in):

HUD Relationship to Head of Household (check 1):

_____Self (head of household)
_____Head of Household's spouse or partner
_____Head of Household's other relation member
_____Other: Non-relation member
_____**Head of Household's Child**
_____Client doesn't know
_____Client prefers not to answer

Date of Birth (DOB) (write in DOB and check 1 data quality option): _____/_____/_____

_____Full DOB _____Approx. or partial DOB _____Client doesn't know _____Client prefers not to answer

Race and Ethnicity: (check as many as applicable):

_____ American Indian, Alaska Native, or Indigenous
_____ Asian or Asian American
_____ Black, African American, or African
_____ Hispanic/Latina/o
_____ Middle Eastern or North African
_____ Native Hawaiian or Pacific Islander
_____ White

Additional Detail (if desired): _____

_____ Client doesn't know
_____ Client prefers not to answer

Sex:

_____ Male
_____ Client Doesn't Know

_____ Female
_____ Client Prefers Not to Answer

Does client have a disability of long duration (check 1 and complete grid below):

_____Yes _____No _____Client doesn't know _____Client prefers not to answer

DISABILITY DETAIL Circle for each disability type**:** **Y=Yes** **N=No** **DK=Doesn't Know** **PNA=Prefers not to answer**

Disability Type	Has disability	**IF YES:**	Expected to be of long continued and indefinite duration AND substantially impairs ability to live independently
Alcohol use disorder	Y N DK PNA		Y N DK PNA
Drug use disorder	Y N DK PNA		Y N DK PNA
Both alcohol and drug use disorders	Y N DK PNA		Y N DK PNA
Chronic health condition	Y N DK PNA		Y N DK PNA
Developmental disability	Y N DK PNA		Y N DK PNA
HIV/AIDS	Y N DK PNA		Y N DK PNA
Mental health disorder	Y N DK PNA		Y N DK PNA
Physical disability	Y N DK PNA		Y N DK PNA

Covered by health insurance (check 1 and complete grid below):
_____Yes _____No _____Client doesn't know _____Client prefers not to answer

Insurance Type	Yes	No	Insurance Type	Yes	No
MEDICAID			Employer-provided insurance		
MEDICARE			Health insurance through COBRA		
State children's health insurance			Private pay health insurance		
Veteran's Health Administration (VHA)			State health insurance for adults		
Indian Health Services Program			Other:_____		