CHILD APPLICATION

Fill out information pertaining to the child **(1 application for <u>each child</u> in the household)**

Screening Date: _ _ / _ _ / _ _ _ _ **Staff:** _____
Assessment Type (circle one) Entry Annual During Program Enrollment Exit
Referral Source: ☐ Self ☐ Community Provider (Name:_____) ☐ School District _____

First Name:_____ **MI:** _____ **Last Name:**_____ **Suffix:**_____

Social Security #_____-_____-_____ **Date of Birth:** _____

Relationship to head of household:

☐Son ☐Daughter ☐Dependent child *(check one)* ☐Niece ☐Grandchild ☐Nephew ☐Other, describe: _____	☐Self ☐Spouse or Partner ☐Other Non-Family Describe: _____	☐Other Family Member *(check one)* ☐Brother ☐Sister ☐Other, describe: _____

<u>Child Education Only (ages 5-17)</u>

Currently Enrolled in School: ☐ Yes ☐ No ☐ Unsure ☐ Client prefers not to answer.
If yes, name of child's school_____
If yes, was/is the child connected with a School Liaison? ☐ Yes ☐ No ☐ Unsure ☐ Client prefers not to answer
If yes, type of school ☐ Public ☐ Private ☐ Unsure ☐ Client prefers not to answer.

	HEALTH INSURANCE		
☐	Medicaid	☐	Employer-Provided Health Insurance
☐	Medicare	☐	Health Insurance obtained through COBRA
☐	State Children's Health Insurance Program (CHIP)	☐	Private Pay Health Insurance
☐	Veteran's Health Administration (VHA)	☐	Indian Health Services Program
☐	Other (Source:)	☐	State Health Insurance for Adults

Gender: **(check all that apply)** ☐ Man (Boy, if child) ☐ Transgender ☐ Non-Binary
☐ Woman (Girl, if child) ☐ Questioning ☐ Culturally Specific Identity (e.g., Two-Spirit)
☐ Different Identity (describe: _____)

Race and Ethnicity: ☐ White ☐ Black, African American, or African ☐ American Indian, Alaskan Native or Indigenous
☐ Asian or Asian American ☐ Native Hawaiian or Pacific Islander
☐ Middle Eastern or North African ☐ Hispanic/Latina/e/o

Has your child received any income in the past 30 days? Yes _____ No _____ Unsure _____
If yes, what is the source of income: _____
How much income has your child received in the past 30 days? $_____

Does your child have a disabling condition? Yes_____ No _____ Unsure _____ Refused _____

	BARRIERS (check all that apply)	
☐	Alcohol Use Disorder	Indefinite? Yes ___ No ___ Unsure ___ Client prefers not to answer ___
☐	Chronic Health Condition	Indefinite? Yes ___ No ___ Unsure ___ Client prefers not to answer ___
☐	Developmental Disability	
☐	Drug Use Disorder	Indefinite? Yes ___ No ___ Unsure ___ Client prefers not to answer ___
☐	HIV/AIDS	
☐	Mental Health Disorder	Indefinite? Yes ___ No ___ Unsure ___ Client prefers not to answer ___
☐	Physical Disability	Indefinite? Yes ___ No ___ Unsure ___ Client prefers not to answer ___
☐	**NONE**— Child has no reported barriers	

****Office Staff Only**
Date of HMIS Program Enrollment _____