# HMIS Data Collection Form – CoC Program - Households

Minor

FOR USE BY COC-FUNDED PROJECTS THAT SERVE HOUSEHOLDS WITH MORE THAN ONE PERSON

## HOUSEHOLD MEMBER NAME

This form is for dependent children only. Print additional copies as needed.

| First Name | MI | Last Name | Aliases |
|---|---|---|---|
| | | | |

## FEDERAL REPORTING REQUIREMENTS

### RELATIONSHIP TO HEAD OF HOUSEHOLD (HOH)

☐ HoH's child ☐ HoH's other relation member ☐ HoH's spouse or partner ☐ Other: non-relation member ☐ Unknown

### ENROLLMENT COC

☐ AK-500 Anchorage Continuum of Care
☐ AK-501 Alaska Balance of State Continuum of Care

## HOUSING MOVE-IN INFORMATION (for housing projects only)

IF THE CLIENT HAS NOT MOVED INTO HOUSING AT PROJECT START, LEAVE THIS FIELD BLANK IN HMIS.

### HOUSING MOVE-IN DATE

## CLIENT DEMOGRAPHICS

### DATE OF BIRTH

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

☐ Full DOB ☐ Partial DOB

### RACE AND ETHNICITY

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

☐ American Indian, Alaska Native, or Indigenous
☐ Asian or Asian American
☐ Black, African American, or African
☐ Hispanic/Latina/e/o
☐ Middle Eastern or North African
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Additional (specify):

### GENDER

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

☐ Woman (Girl, if child)
☐ Man (Boy, if child)
☐ Culturally Specific Identity (e.g., Two-Spirit)
☐ Transgender
☐ Non-Binary
☐ Questioning
☐ Different Identity (specify):

## HEALTH INSURANCE COVERAGE INFORMATION

### COVERED BY HEALTH INSURANCE?

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

☐ Yes (If yes, select answer for each type below.)
☐ No (If no, answer No for all types in HMIS.)

| HEALTH INSURANCE TYPES (HUD TABLE) | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Medicaid | ☐ | ☐ | Health Insurance through COBRA | ☐ | ☐ |
| Medicare | ☐ | ☐ | Private Pay Health Insurance | ☐ | ☐ |
| State Children's Health Insurance Program | ☐ | ☐ | State Health Insurance for Adults | ☐ | ☐ |
| Veteran's Health Administration | ☐ | ☐ | Indian Health Services Program | ☐ | ☐ |
| Employer-Provided Health Insurance | ☐ | ☐ | Other (specify): | ☐ | ☐ |

## DISABLING CONDITION INFORMATION

### DISABLING CONDITIONS?

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

☐ Yes (If yes, select answer for each type below.)
☐ No (If no, answer No for all types in HMIS.)

| DISABLING CONDITIONS (HUD TABLE) | Yes | No | Doesn't know | Prefers not to answer | | Yes | No | Doesn't know | Prefers not to answer |
|---|---|---|---|---|---|---|---|---|---|
| Alcohol Use Disorder | ☐ | ☐ | ☐ | ☐ | | ☐ | ☐ | ☐ | ☐ |
| Both Alcohol and Drug Use | ☐ | ☐ | ☐ | ☐ | | ☐ | ☐ | ☐ | ☐ |
| Chronic Health Condition | ☐ | ☐ | ☐ | ☐ | If Yes, does it affect their ability to live independently? | ☐ | ☐ | ☐ | ☐ |
| Developmental | ☐ | ☐ | ☐ | ☐ | | | | | |
| Drug Use Disorder | ☐ | ☐ | ☐ | ☐ | | ☐ | ☐ | ☐ | ☐ |
| HIV / AIDS | ☐ | ☐ | ☐ | ☐ | | | | | |
| Mental Health Disorder | ☐ | ☐ | ☐ | ☐ | | ☐ | ☐ | ☐ | ☐ |
| Physical Disability | ☐ | ☐ | ☐ | ☐ | | ☐ | ☐ | ☐ | ☐ |

| AK DISABLING CONDITIONS | Yes | No | Doesn't know | Prefers not to answer |
|---|---|---|---|---|
| Alzheimer's Disease and Related Dementias | ☐ | ☐ | ☐ | ☐ |
| Chronic Alcoholism or other substance use disorder | ☐ | ☐ | ☐ | ☐ |
| Intellectual or Developmental Disabilities | ☐ | ☐ | ☐ | ☐ |
| Mental Illness | ☐ | ☐ | ☐ | ☐ |
| Traumatic Brain Injuries | ☐ | ☐ | ☐ | ☐ |

## ALASKA NATIVE REGIONAL CORPORATION

### PRIMARY REGIONAL CORPORATION

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

| | | | | |
|---|---|---|---|---|
| ☐Not Affiliated | ☐Sealaska | ☐Doyon Limited | ☐Calista | ☐Chugach Alaska |
| ☐Bering Straits Native | ☐Ahtna | ☐13th Regional | ☐Koniag | ☐NANA Regional |
| ☐Cook Inlet Regional | ☐Bristol Bay Native | ☐Aleut | ☐Arctic Slope Regional | |

### SECONDARY REGIONAL CORPORATION, IF APPLICABLE: