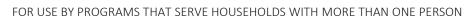
HMIS Data Collection Form – Common Data Elements - Households





HOUSEHOLD MEMBER NAI		rint additional coninc	as pandad		
This form is for dependent ch	naren oniy. F	Tint additional copies	as needed.		
First Name	MI	Last Name		Aliases	
FEDERAL REPORTING REQU	JIREMENT	S			
RELATIONSHIP TO HEAD OF	F HOUSEH	OLD (HOH)			
☐ HoH's child ☐ HoH's (other relatio	n member □ HoH's	spouse or partner	Other: non-relation i	member 🔲 Unknown
ENROLLMENT COC					
☐ AK-500 Anchorage Continu	um of Care				
☐ AK-501 Alaska Balance of S		um of Care			
HOUSING MOVE-IN INFOR	•	·	• •		
IF THE CLIENT HAS NOT MOVE	ED INTO HOU	JSING AT PROJECT STA	ART, LEAVE THIS FIELD E	BLANK IN HMIS.	
HOUSING MOVE-IN DATE					
CLIENT DEMOGRAPHICS					
DATE OF BIRTH					☐ Client doesn't know☐ Client prefers not to answer
			□ F	Full DOB □ Partial D	_ '
				-	
RACE AND ETHNICITY					☐ Client doesn't know☐ Client prefers not to answer
☐ American Indian, Alaska Na	tive, or Indig		astern or North African		_
☐ Asian or Asian American ☐ Black, African American, or	African	□ Native Ha □ White	awaiian or Pacific Island	er	
☐ Hispanic/Latina/e/o	ATTEUT	☐ Additiona	al (specify):		
GENDER					☐ Client doesn't know☐ Client prefers not to answer
☐ Woman (Girl, if child)		□ Non-Bina			
☐ Man (Boy, if child)☐ Culturally Specific Identity (e.g Two-Sn	☐ Question	ing Identity (specify):		
☐ Transgender	o., . ***	,	.ac.inty (apolity).		

HMIS Data Collection Form – Common Program Specific Data Elements - Households FOR USE BY PROGRAMS THAT SERVE HOUSEHOLDS WITH MORE THAN ONE PERSON

HEALTH INSURANCE COVERAGE	INFO	RMA	TION									
											☐ Client does	n't kn ou
COVERED BY HEALTH INSURANCE?								_	ers not to answer			
☐ Yes (If yes, select answer for each ☐ No (If no, answer No for all types i												
HEALTH INSURANCE TYPES (HUD	TABL	E)		Yes No)						Yes No	
Medicaid □ □ Health Insurance through COBRA								OBRA				
Medicare 🗆 🗅 Private Pay Health Insurance												
O O								te Health Insurance for Adults				
Veteran's Health Administration □ □ □ Employer-Provided Health Insurance □ □												
Employer-Provided Health Insurance												
DISABLING CONDITION INFORM	IATION	N										
DISABLING CONDITIONS?											☐ Client does ☐ Client prefe	n't know ers not to answer
☐ Yes (If yes, select answer for each	type be	elow.)										
☐ No (If no, answer No for all types i	in HMIS	5.)										
DISABLING CONDITIONS												
(HUD TABLE)		Yes	No	Doesn't know	Prefers to ans				Yes	No	Doesn't know	Prefers not to answer
Alcohol Use Disc	order					WCI] 🗆		NIIOW	
Both Alcohol and Drug												
Chronic Health Cond	_						If Ves	does it				
Developme	ental						affect					
Drug Use Disc	order						ability	to live				
HIV /	AIDS						indepe	endently?				
Mental Health Disc	order											
Physical Disa	bility											
AK DISABLING CONDITIONS					Yes	N	О	Doesn't k	now	Prefers	s not to ansv	ver
Alzheimer's Disease and Related Dementias]					
Chronic Alcoholism or other substance use disorder												
Intellectual or Developmental Disabilities Mental Illness												
Mental Illness Traumatic Brain Injuries												
	11	rauma	atic Bra	in injuries								
ALASKA NATIVE REGIONAL COR	PORA	ΓΙΟΝ										
PRIMARY REGIONAL CORPORATI	ION										Client does	n't know ers not to answer
				ovon Limita	2d	ПСа	lista					13 HOL LO GHSWEI
□Not Affiliated □Sealaska □Doyon Limite □Bering Straits Native □Ahtna □13 th Regional □Cook Inlet Regional □Bristol Bay Native □Aleut				L □Koniaσ □Chu				_	ach Alaska A Regional			
SECONDARY REGIONAL CORPOR	ATION	IE ^	ם וכם	`ARI E								