

HMIS CLIENT CAS ADDITIONAL FAMILY MEMBER PAGE

COALITION TO END HOMELESSNESS IN WICHITA/SEDGWICK COUNTY

(KS-502 – WICHITA/SEDGWICK COUNTY CONTINUUM OF CARE)

Note: Additional family members on this form are only children under 18.

AGENCY INFORMATION

Agency: _____

Project: _____

Staff Name: _____

Date of Engagement: ____ / ____ / ____

HEAD OF HOUSEHOLD NAME OR HMIS # _____

ADDITIONAL FAMILY MEMBER #1

This person is the ☐ Child ☐ Grandchild ☐ Other family member ☐ Non-family member

Verified/available IDs (check all that apply) ☐ Birth Cert. ☐ State ID ☐ SSN Card ☐ Municipal ID ☐ DL ☐ Other: _____

Name: First _____ MI _____ Last _____ Preferred: _____

DOB: ____ / ____ / ____ Social Security Number: _____ ☐ Doesn't know/have one

Address: _____

City: _____ ZIP: _____ Phone/Email: _____

Sex: ☐ Woman (Girl, if child) ☐ Man (Boy, if child) ☐ Prefers not to answer

Race & Ethnicity (check all):

☐ 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 Race & Ethnicity Details: _____

Translation Needed: ☐ Yes ☐ No If Yes, language: _____

Y=Yes N=No, LT = Long-term, a condition expected to be of long continued and indefinite duration

Disabling Conditions & Barriers

Condition	Y	N	LT	Y	LT	N	Condition	Y	N	LT	Y	LT	N
Disabling Condition	<input type="checkbox"/>	<input type="checkbox"/>					Mental Health Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Physical Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		Substance Use Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Developmental Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		Chronic Health Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>

Health Insurance? ☐ Yes ☐ No

☐ Medicaid ☐ Medicare ☐ SCHIP/CHIP ☐ VHA ☐ Employer ☐ COBRA ☐ Private ☐ State Adult ☐ IHS ☐ Other: _____

ADDITIONAL FAMILY MEMBER #2

This person is the ☐ Child ☐ Grandchild ☐ Other family member ☐ Non-family member

Verified/available IDs (check all that apply) ☐ Birth Cert. ☐ State ID ☐ SSN Card ☐ Municipal ID ☐ DL ☐ Other: _____

Name: First _____ MI _____ Last _____ Preferred: _____

DOB: ____ / ____ / ____ Social Security Number: _____ ☐ Doesn't know/have one

Address: _____

City: _____ ZIP: _____ Phone/Email: _____

Sex: ☐ Woman (Girl, if child) ☐ Man (Boy, if child) ☐ Prefers not to answer

Race & Ethnicity (check all):

☐ 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 Race & Ethnicity Details: _____

Translation Needed: ☐ Yes ☐ No If Yes, language: _____

Y=Yes, N=No, LT = Long-term, a condition expected to be of long continued and indefinite duration

Disabling Conditions & Barriers

Condition	Yes	No	LT	Yes	LT	No	Condition	Yes	No	LT	Yes	LT	No
Disabling Condition	<input type="checkbox"/>	<input type="checkbox"/>					Mental Health Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Physical Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		Substance Use Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>
Developmental Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		Chronic Health Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>

Health Insurance? ☐ Yes ☐ No

☐ Medicaid ☐ Medicare ☐ SCHIP/CHIP ☐ VHA ☐ Employer ☐ COBRA ☐ Private ☐ State Adult ☐ IHS ☐ Other: _____

Additional Family Member

Coalition to End Homelessness in Wichita/Sedgwick County

Last Amended and Approved: 10/27/2025