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	☐	☐			Mental Health Disorder	☐	☐	☐	☐
Physical Disability	☐	☐	☐	☐	Substance Use Disorder	☐	☐	☐	☐
Developmental Disability	☐	☐	☐	☐	Chronic Health Condition	☐	☐	☐	☐

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	☐	☐			Mental Health Disorder	☐	☐	☐	☐
Physical Disability	☐	☐	☐	☐	Substance Use Disorder	☐	☐	☐	☐
Developmental Disability	☐	☐	☐	☐	Chronic Health Condition	☐	☐	☐	☐

Health Insurance? ☐ Yes ☐ No

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