

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: _____