

**INSTRUCTIONS:** Complete one fully copy of this form for each additional household member. Paper forms should be stored in the client’s file at the Access Point per CoC regulations. Instructions for the assessor appear throughout the document in orange.

**FAMILY MEMBER INFORMATION:** Complete the client's identifying information. Name and SSN have associated data quality fields. Data quality fields are used to indicate the reason full information wasn't collected. Name and social security number data quality fields allow users to indicate when a client doesn't know or refuses to provide information. If the required data is collected then ClientTrack automatically records that full data quality was met.

Assessment date: \_\_\_\_\_ **First Name\*:** \_\_\_\_\_

**Middle Name:** \_\_\_\_\_ **Last Name\*:** \_\_\_\_\_

**Suffix:** \_\_\_\_\_ **Name Quality\*:** Full Name Reported

**SSN:** \_\_\_\_\_

**SSN Quality\*:**  Full SSN     Client Doesn't Know     Client Prefers Not to Answer

Data Not Collected

**BASIC CLIENT DEMOGRAPHICS:**

**Birth Date:** \_\_\_\_\_ **Client Age:** \_\_\_\_\_

**Date of birth quality\*:** Full DOB Reported

**Additional Race and Ethnicity Detail:** \_\_\_\_\_

**Race (choose all that apply) \*:**

- |  |   |
|--|---|
| <input type="checkbox"/> American Indian, Alaska Native, or Indigenous | <input type="checkbox"/> Hispanic/Latina/e/o          |
| <input type="checkbox"/> Asian or Asian American                       | <input type="checkbox"/> White                        |
| <input type="checkbox"/> Middle Eastern or North African               | <input type="checkbox"/> Client doesn't know          |
| <input type="checkbox"/> Black, African American, or African           | <input type="checkbox"/> Client prefers not to answer |
| <input type="checkbox"/> Native Hawaiian or Pacific Islander           | <input type="checkbox"/> Data not collecte            |

**Gender (choose all that apply)\*:**

- |  |   |
|--|---|
| <input type="checkbox"/> Woman (Girl, if child)                          | <input type="checkbox"/> Questioning                  |
| <input type="checkbox"/> Man (Boy, if child)                             | <input type="checkbox"/> Different Identity           |
| <input type="checkbox"/> Culturally Specific Identity (e.g., Two-Spirit) | <input type="checkbox"/> Client doesn't know          |
| <input type="checkbox"/> Transgender                                     | <input type="checkbox"/> Client prefers not to answer |
| <input type="checkbox"/> Non-Binary                                      | <input type="checkbox"/> Data not collected           |

**Pronouns (if given):** \_\_\_\_\_ **Sexual Orientation:** \_\_\_\_\_

*The following two questions are only required for persons age 18+:*

**Veteran Status\*:** \_\_\_\_\_ **Marital Status:** \_\_\_\_\_

**CONTACT INFORMATION:**

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Email: \_\_\_\_\_

Primary Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Msg Phone: \_\_\_\_\_

**UNIVERSAL DATA ASSESSMENT:**

Assessment Date\*: \_\_\_\_\_

Assessor Name\*: \_\_\_\_\_

Disabling Condition\*:  Yes  No  Client Doesn't Know

Client Prefers Not to Answer  Data Not Collected

*If yes, complete the following chart. Otherwise, skip to Health Insurance section.*

**BARRIERS/SPECIAL NEEDS**

<b>ALCOHOL ABUSE</b>		
Barrier present? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>If yes:</i>	Condition is indefinite? <input type="checkbox"/> Yes <input type="checkbox"/> No	Explanation:
<b>CHRONIC HEALTH CONDITION</b> (defined as a diagnosed condition that is more than 3 months in duration and is either not curable or has residual effects that limit daily living and require adaptation in function or special assistance)		
Barrier present? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>If yes:</i>	Condition is indefinite? <input type="checkbox"/> Yes <input type="checkbox"/> No	Explanation:
<b>DEVELOPMENTAL DISABILITY</b>		
Barrier present? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>If yes:</i>	Condition is indefinite? <input type="checkbox"/> Yes <input type="checkbox"/> No	Explanation:
<b>DRUG ABUSE</b>		
Barrier present? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>If yes:</i>	Condition is indefinite? <input type="checkbox"/> Yes <input type="checkbox"/> No	Explanation:
<b>HIV/AIDS</b>		
Barrier present? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>If yes:</i>	Condition is indefinite? <input type="checkbox"/> Yes <input type="checkbox"/> No	Explanation:

MENTAL HEALTH		
Barrier present? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>If yes:</b>	Condition is indefinite? <input type="checkbox"/> Yes <input type="checkbox"/> No	Explanation:
OTHER		
Barrier present? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>If yes:</b>	Condition is indefinite? <input type="checkbox"/> Yes <input type="checkbox"/> No	Explanation:
PHYSICAL DISABILITY		
Barrier present? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>If yes:</b>	Condition is indefinite? <input type="checkbox"/> Yes <input type="checkbox"/> No	Explanation:
FELONY CONVICTION		
Barrier present? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>If yes:</b>	Condition is indefinite? <input type="checkbox"/> Yes <input type="checkbox"/> No	Explanation:
HISTORY OF FOSTER CARE		
Barrier present? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>If yes:</b>	Condition is indefinite? <input type="checkbox"/> Yes <input type="checkbox"/> No	Explanation:

**HEALTH INSURANCE (choose all that apply):**

- |   |  |
|---|--|
| <input type="checkbox"/> Private  | <input type="checkbox"/> Military Insurance                                      |
| <input type="checkbox"/> Private- Individual                                | <input type="checkbox"/> Other Public  |
| <input type="checkbox"/> Private – Employer                                 | <input type="checkbox"/> State Funded  |
| <input type="checkbox"/> Health insurance obtained through COBRA            | <input type="checkbox"/> Combined Children’s Health Insurance / Medicaid Program |
| <input type="checkbox"/> Medicare   | <input type="checkbox"/> Indian Health Service (HIS)                             |
| <input type="checkbox"/> Medicaid   | <input type="checkbox"/> Other   |
| <input type="checkbox"/> State Children’s Health Insurance Program (S-CHIP) | <input type="checkbox"/> No Insurance  |

**Assessor: If this household member is age 18 or older, continue to the following pages. If they are under 18, stop here.**

Complete the following section if client identifies as a veteran. Otherwise, skip to Income Assessment

**VETERAN ASSESSMENT**

**Branch and Discharge status:** Please select the branch and discharge status. The HMIS Data Manual provides the following instructions for veterans serving in more than one branch: “For veterans who served in more than one branch of the military, select the branch in which the veteran spent the most time. In the event that a client’s discharge status is upgraded during enrollment, the record should be edited to reflect the change.”

- Branch of the military\*:**  Army     Air Force     Navy     Marines     Coast Guard  
 Client doesn’t know

**Discharge status\*:** Honorable General under honorable conditions Under other than honorable conditions (OTH) Bad conduct Dishonorable Uncharacterized Client doesn't know

**Military Service Dates:** In the interest of data quality ClientTrack provides date fields and encourages users to enter exact dates if possible. If not, use the first of the year or another standard date determined by your organization. For HMIS purposes, ClientTrack will always calculate years of military service only using year.

**Service entry date\*:** \_\_\_\_\_ **Service exit date:** \_\_\_\_\_

**Please select theatre(s) of operations(s): *Circle all that apply***

- Theatre of Operations: World War II
- Theatre of Operations: Vietnam War
- Theatre of Operations: Persian Gulf War (Operation Desert Storm)
- Theatre of Operations: Afghanistan (Operation Enduring Freedom)
- Theatre of Operations: Iraq (Operation Iraqi Freedom)
- Theatre of Operations: Iraq (Operation New Dawn)
- Theatre of Operations: Other Peace-Keeping Operations or Military Interventions (such as Lebanon, Panama, Somalia, Bosnia, Kosovo)
- Theatre of Operations: Korean War

**INCOME.** Indicate below the client's sources of **MONTHLY** income, non-cash benefits, and expenses. The following instructions are quoted from the HMIS Data Manual:

- When a client has income, but does not know the exact amount, a "Yes" response should be recorded for both the overall income question and the specific source, and the income amount should be estimated.
- Income received by or on behalf of a minor child should be recorded as part of household income under the Head of Household, unless the federal funder in the HMIS Program Specific Manual instructs otherwise. Income should be recorded at the client-level for heads of household and adult household members. Projects may choose to collect this information for all household members including minor children, as long as this does not interfere with accurate reporting per funder requirements. Projects collecting data through client interviews should ask clients whether they receive income from each of the sources listed rather than asking them to state the sources of income they receive.
- Income data should be recorded only for sources of income that are current as of the information date (i.e. have not been specifically terminated). As an example, if a client's employment has been terminated and the client has not yet secured additional employment, the response for Earned income would be "No." As a further example, if a client's most recent paycheck was 2 weeks ago from a job in which the client was working full time for \$15.00/hour, but the client is currently working 20 hours per week for \$12.00 an hour, record the income from the job the client has at the time data are collected (i.e. 20 hours at \$12.00 an hour).

<input type="checkbox"/> <b>ALIMONY</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>CHILD SUPPORT</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>EMPLOYMENT</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>OTHER INCOME</b>		

<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>PRIVATE DISABILITY INSURANCE</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>SOCIAL SECURITY</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>SOCIAL SECURITY DISABILITY</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>SUPPLEMENTAL SECURITY INCOME</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>TANF</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>UNEMPLOYMENT BENEFITS</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>VETERAN BENEFITS</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>VETERAN'S DISABILITY</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>VETERAN'S PENSION</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>WORKER COMPENSATION BENEFITS</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>PENSION OR RETIREMENT INCOME FOR A FORMER JOB</b>		
<i>If yes:</i>	Description:	Monthly amount:

**NON-CASH BENEFITS: Choose all that apply**

<input type="checkbox"/> <b>FOOD STAMPS</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>HEALTHY INDIANA PLAN</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>HOOSIER HEALTHWISE</b>		
<i>If yes:</i>	Description:	Monthly amount:

<input type="checkbox"/> <b>MEDICAID</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>MEDICARE</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>OTHER NON-CASH BENEFITS</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>PRIVATE HEALTH INSURANCE</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>SECTION 8, PUBLIC HOUSING, OR OTHER RENTAL ASSISTANCE</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>STATE CHILDREN'S HEALTH INSURANCE PROGRAM</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>TEMPORARY RENTAL ASSISTANCE</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>VETERAN'S HEALTH CARE</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>WISHARD ADVANTAGE</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>TANF CHILD CARE SERVICES</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>TANF TRANSPORTATION SERVICES</b>		
<i>If yes:</i>	Description:	Monthly amount:
<input type="checkbox"/> <b>OTHER TANF-FUNDED SERVICES</b>		
<i>If yes:</i>	Description:	Monthly amount:

-----**End of CES Household Member Enrollment**-----

Please complete this document for each additional household member.