

Date _____

HMIS ID# _____

HMIS Program Enrollment Form

To be completed on all **MINORS** over the age of 18 in the household.

Basic Information

Name: _____ SSN: _____ Date of Birth: _____

Relationship to Head of Household: _____

Which Gender does the minor identify as?

- Female
- Male
- Transgender
- Questioning
- Non Binary / genderfluid / agender
- Don't know
- Refused

Which Ethnicity is the minor?

- Non-Hispanic/Non-Latino
- Hispanic/Latino
- Don't know
- Refused

What Race(s) is the minor? Select all that apply

- American Indian/Alaska Native
- Black/African American/African
- White
- Asian / Asian American
- Native Hawaiian / Pacific Islander
- Doesn't know
- Refused

Health Insurance

Do they have health insurance?

- Yes
- No
- Don't know

If yes, what type(s) of Health Insurance (select all that apply):

- Medicaid – **What Medicaid plan:** _____
- Medicare
- State Children's Health Ins
- (VA) Medical Services
- Employer Provided Health Ins
- Health Ins Obtained via Cobra
- Private Pay Health Ins
- State Health Ins for Adults
- Indian Health Services Program
- Other

Disability Information

Do they have a disabling condition that significantly impairs their ability to perform daily activities?

- Yes
- No

If yes, what kind of Disability do you have? (Select All that apply)

- Alcohol Use Disorder
- Chronic Health Condition
- Developmental Disability
- Drug Use Disorder
- HIV/AIDS
- Mental Health Disorder
- Physical Disability

Is the disability indefinite? (Expected to last a very long time)

- Yes
- No
- Don't know