|  |
| --- |
| **MCI ID:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **HMIS ID:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Staff Initials/Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Grant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Program Enrollment Date: \_\_\_\_\_\_\_\_\_\_\_\_\_** |

**HMIS ADULT/CHILD ANNUAL FORM**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Name*** |  | ***Anniversary Date*** |  | ***Assessment/Information Date*** |
|  |  |  |  |  |

**When completing an APR for the HoH, complete one for ALL members**

\*Check all demographic information on the household screen in HMIS to ensure it is all filled in and there is no client refused, client doesn’t know, data not collected\*

|  |  |
| --- | --- |
| **Name** | **Relationship to HOH**  **(child, spouse, other relation member, other non-relation member, HoH)** |
|  | Choose an item. |
|  | Choose an item. |
|  | Choose an item. |
|  | Choose an item. |
|  | Choose an item. |

*Additional Household Members (please fill out a form for each household member mentioned below)*

*Domestic Violence*

|  |  |  |
| --- | --- | --- |
| Victim/Survivor | When did this happen? | Currently Fleeing |
| Choose an item. | Choose an item. | Choose an item. |

*Employment (for anyone 18+)*

|  |  |
| --- | --- |
| Yes | No |
| Choose an item. | Choose an item. |

***Income (for anyone 18+)***

YES If Yes, complete table below.  NO If No, skip to the next table.

|  |  |  |  |
| --- | --- | --- | --- |
| Source | If yes, Amount - *monthly* | Source | If yes, Amount - *monthly* |
| Earned Income (Employment) | $ | VA Service-Connected Disability Compensation | $ |
| Unemployment Insurance | $ | VA Non-svc Connected Disability Pension | $ |
| GA | $ | Private Disability Insurance | $ |
| Retirement Income from Social Security | $ | Cash Assistance/TANF | $ |
| Worker’s Compensation | $ | Alimony or Other Spousal Support | $ |
| SSI | $ | Child Support | $ |
| SSDI | $ | UTA | $ |
|  |  | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | $ |

|  |  |  |  |
| --- | --- | --- | --- |
| ***Connection to SOAR*** | Choose an item. | ***Total Monthly Income*** | $ |

*Non-cash Benefits (for anyone 18+)*

**YES** If Yes, complete table below.

**NO** If No, skip to the next table.

|  |
| --- |
| Source (select all that apply) |
| SNAP (Food Stamps)  WIC  TANF Childcare Services  TANF Transportation Services  Other TANF-funded Services  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

*Health Insurance (for all clients)*

**YES** If Yes, complete table below.

**NO** If No, skip to the next table.

|  |
| --- |
| Source (select all that apply) |
| Medicaid  Medicare  State Children’s Health Insurance Program (CHIP)  VA medical services  Employer Provided health insurance  Health insurance obtained through COBRA  Private Pay Health Insurance  State Health Insurance for Adults  Indian Health Services Program |

***Education***

|  |  |  |  |
| --- | --- | --- | --- |
| **Adults 18+ and Children 6+** | | | |
| **Last Grade Completed** | | **School Status** | |
| Choose an item. | | Choose an item. | |
| Children Age 0-5 | | | |
| Has the child received a developmental screening? | | | Choose an item. |
| **IF NO,** has the child been referred to an agency for a developmental screening? | | | Choose an item. |
| **IF NO,** was/will a developmental screening be completed during program enrollment? | | | Choose an item. |
| Is the family intending to send the child to an early learning program? | | | Choose an item. |
| Is the child enrolled? | | | Choose an item. |
| Young Adults 18-24 & Children Age 6+ | | | |
| Enrollment status | Choose an item. | | |
| **If not enrolled, why?** | Choose an item. If other, please specify: Click or tap here to enter text. | | |
| Name of district |  | | |
| Name of school |  | | |
| Referral to School District McKinney-Vento Homeless Liaison? | Choose an item. | | |

*Physical and Mental Health*

|  |  |  |  |
| --- | --- | --- | --- |
| Disabling Condition | Choose an item. |  |  |
| Dental Health Status | Choose an item. | Mental Health Status | Choose an item. |
| Type | **Expected to be long-term?** | Type | Expected to be long-term? |
| Physical | Choose an item. | HIV/AIDS | |
| Developmental | |  |  |
| Chronic health condition | Choose an item. |  |  |
| Mental health disorder | Choose an item. | Alcohol use disorder | Choose an item. |
| Drug use disorder | Choose an item. | Alcohol and drug use disorder | Choose an item. |

Services Provided *Optional*

|  |  |
| --- | --- |
| Date of Service Start Date | Click or tap to enter a date. |
| Date of Service End Date (leave blank if there is no end date yet) | Click or tap to enter a date. |
| Service Type | Choose an item. |

*Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Staff Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*