|  |
| --- |
| **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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*