Chittenden County Homeless Alliance
*Working to End Homelessness*

# COORDINATED ENTRY HMIS DATA ENTRY FORM - MINORS

**Date**: __ __ /__ __ /__ __ __ __

## Client Record

**Client Name**: First_____ Middle _____ Last _____

Name Quality: ☐Full ☐Partial ☐Don't Know ☐Refused

**Social Security Number:** __ __ __ - __ __ - __ __ __ __ SSN Quality: ☐Full ☐ Partial ☐Doesn't Know ☐Refused

## Client Demographics

**Date of Birth**: __ __ /__ __ /__ __ __ __ DOB Quality: ☐ Full DOB Reported ☐ Partial ☐ Doesn't Know ☐Refused

**Gender:**

- ☐ Female
- ☐ Male
- ☐ A Gender Other Than Singularly Female or Male
- ☐ Transgender
- ☐ Questioning
- ☐ Refused
- ☐ Doesn't Know

**Race:**

- ☐ American Indian/Alaskan Native/ Indigenous
- ☐ Asian/Asian American
- ☐ Black/African/African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Doesn't Know
- ☐ Refused

**Ethnicity:**

- ☐ Hispanic/Latino
- ☐ Doesn't Know
- ☐ Non-Hispanic/Latino
- ☐ Refused

## Head of Household Information

**Relationship to Head of Household:**

- ☐ Child
- ☐ Other Relation
- ☐ Other: Non-Relation

**HOH Name:** First_____Last_____

**HOH Date of Birth:** __ __ /__ __ / __ __ __ __

## Disabling Conditions

| | | | |
|---|---|---|---|
| **Physical Condition** | ☐ Yes<br>☐ Doesn't Know | ☐ No<br>☐ Refused | **If yes, is it a long-term condition?**<br>☐ Yes ☐ No<br>☐ Doesn't Know ☐ Refused |
| **Developmental Disability** | ☐ Yes<br>☐ Doesn't Know | ☐ No<br>☐ Refused | |
| **Chronic Health Condition** | ☐ Yes<br>☐ Doesn't Know | ☐ No<br>☐ Refused | **If yes, is it a long-term condition?**<br>☐ Yes ☐ No<br>☐ Doesn't Know ☐ Refused |
| **HIV - AIDS** | ☐ Yes<br>☐ Doesn't Know | ☐ No<br>☐ Refused | |
| **Mental Health Disorder** | ☐ Yes<br>☐ Doesn't Know | ☐ No<br>☐ Refused | **If yes, is it a long-term condition?**<br>☐ Yes ☐ No<br>☐ Doesn't Know ☐ Refused |
| **Substance Use Disorder** | ☐ Yes, Alcohol Use Disorder<br>☐ Yes, Drug Use Disorder<br>☐ Yes, Both Alcohol and Drug Use Disorders | | ☐ No<br>☐ Doesn't Know<br>☐ Refused |

## Health Insurance Information

**Health insurance received from any source in the last 30 days?** ☐ Yes ☐ No ☐ Doesn't Know ☐ Refused

If yes, continue below and if not, skip this section.

| | | | | |
|---|---|---|---|---|
| **Medicaid** | ☐ Yes | ☐ No | ☐ Doesn't Know | ☐ Refused |
| **Medicare** | ☐ Yes | ☐ No | ☐ Doesn't Know | ☐ Refused |
| **State Children Health Insurance Program** | ☐ Yes | ☐ No | ☐ Doesn't Know | ☐ Refused |
| **VA Medical Services** | ☐ Yes | ☐ No | ☐ Doesn't Know | ☐ Refused |
| **Employer – Provided Health Insurance** | ☐ Yes | ☐ No | ☐ Doesn't Know | ☐ Refused |
| **COBRA** | ☐ Yes | ☐ No | ☐ Doesn't Know | ☐ Refused |
| **Private Pay Health Insurance** | ☐ Yes | ☐ No | ☐ Doesn't Know | ☐ Refused |
| **State Health Insurance for Adults** | ☐ Yes | ☐ No | ☐ Doesn't Know | ☐ Refused |
| **Indian Health Services Program** | ☐ Yes | ☐ No | ☐ Doesn't Know | ☐ Refused |
| **Other Health Insurance** | ☐ Yes | ☐ No | ☐ Doesn't Know | ☐ Refused |