Additional Household Members

Family Members Last Name, First Name, M.I.	Relationship to Head of Household (HOH)	Gender^	DOB	SSN	Race* & Ethnicity**	Primary Language	Disability Documented		Disability Type^^	Active Military?	
							Yes	No		Yes	No
	H.O.H.						☐	☐		☐	☐
							☐	☐		☐	☐
							☐	☐		☐	☐
							☐	☐		☐	☐
							☐	☐		☐	☐
							☐	☐		☐	☐

***Race Key: N =** American Indian/Alaska Native, **P =** Native Hawaiian/Pacific Islander, **W =** White, **A** = Asian, **B** = Black/African American, **O** = Other
**** Ethnicity Key: H =** Hispanic/Latino, **NON =** Non-Hispanic/Latino

^Gender Key: F = Female**, M =** Male**, MTF =** Trans Male to Female**, FTM =** Trans Female to Male**, GN =** Gender Non-Conforming

^^Disability Types: Alcohol abuse, drug abuse, both alcohol and drug abuse, developmental, HIV/AIDS, mental health problem, physical, chronic health condition, hearing impaired, vision impaired, other

Educational Information		
Highest grade completed by everyone in household:		
Name	**Grade Level**	**Enrolled in school**
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Health Summary		
Name	Covered by health insurance?	Health Insurance Type*
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

***Health insurance types =** MEDICAID, MEDICARE, State Children's Health Insurance Program, Employer – Provided Health Care Insurance, State Health Insurance for adults, Veteran's Administration (VA) Medical Services, Health Insurance obtained through COBRA, Private Pay Health Insurance

	Is client pregnant?	☐ Yes ☐ No
	Due date if pregnant:	