

FOR USE BY PROGRAMS THAT SERVE HOUSEHOLDS WITH MORE THAN ONE PERSON

HOUSEHOLD MEMBER NAME

For dependent children only. Print additional as needed.

First Name	MI	Last Name	Aliases

FEDERAL REPORTING REQUIREMENTS

RELATIONSHIP TO HEAD OF HOUSEHOLD (HOH)

- HoH’s child
 HoH’s other relation member
 HoH’s spouse or partner
 Other: non-relation member
 Unknown

ENROLLMENT COC

- AK-500 Anchorage Continuum of Care
 AK-501 Alaska Balance of State Continuum of Care

HOUSING MOVE-IN INFORMATION (housing projects only)

IF THE CLIENT HAS NOT MOVED INTO HOUSING AT PROJECT START, LEAVE THIS FIELD BLANK IN HMIS.

HOUSING MOVE-IN DATE

CLIENT DEMOGRAPHICS

DATE OF BIRTH

- Client doesn’t know
 Client prefers not to answer

- Full DOB Partial DOB

RACE AND ETHNICITY

- Client doesn’t know
 Client prefers not to answer

- American Indian, Alaska Native, or Indigenous
 Middle Eastern or North African
 Asian or Asian American
 Native Hawaiian or Pacific Islander
 Black, African American, or African
 White
 Hispanic/Latina/e/o
 Additional (specify):

GENDER

- Client doesn’t know
 Client prefers not to answer

- Woman (Girl, if child)
 Non-Binary
 Man (Boy, if child)
 Questioning
 Culturally Specific Identity (e.g., Two-Spirit)
 Different Identity (specify):
 Transgender

DISABLING CONDITION INFORMATION

DISABLING CONDITIONS?	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Yes <input type="checkbox"/> No	

AK DISABLING CONDITIONS	Yes	No	Doesn't know	Prefers not to answer
Alzheimer's Disease and Related Dementias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Alcoholism or other substance use disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual or Developmental Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traumatic Brain Injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ALASKA NATIVE REGIONAL CORPORATION

PRIMARY REGIONAL CORPORATION	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Not Affiliated <input type="checkbox"/> Sealaska <input type="checkbox"/> Doyon Limited <input type="checkbox"/> Calista <input type="checkbox"/> Bering Straits Native <input type="checkbox"/> Ahtna <input type="checkbox"/> 13 th Regional <input type="checkbox"/> Koniag <input type="checkbox"/> Chugach Alaska <input type="checkbox"/> Cook Inlet Regional <input type="checkbox"/> Bristol Bay Native <input type="checkbox"/> Aleut <input type="checkbox"/> Arctic Slope Regional <input type="checkbox"/> NANA Regional	
SECONDARY REGIONAL CORPORATION, IF APPLICABLE:	