

Additional Household Member: Demographics and Additional Information			
First Name:		Last Name:	
DOB:	SSN:	HMIS ID:	
Relationship to Head of Household? <input type="checkbox"/> Child <input type="checkbox"/> Spouse or Partner <input type="checkbox"/> Other Relation Member <input type="checkbox"/> Non-Relation Member			
Have you ever served at least one day active duty in the US Military?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have, or been told you have a disabling condition by a professional?			<input type="checkbox"/> Yes <input type="checkbox"/> No
What gender do you identify as? <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> A gender other than singularly male or female <input type="checkbox"/> Questioning <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused			
What race do you most identify with? <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American (Select all that apply) <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Client refused			
If <u>yes</u> to American Indian or Alaska Native, Tribal affiliation/Enrollment:			
Would you say that you are?		<input type="checkbox"/> Non-Hispanic/Non-Latin(a)(o)(x) <input type="checkbox"/> Hispanic/Latin(a)(o)(x) <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	

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