Additional Household Member	Additional Household Member
Name:	**Name/Relationship to HoH:**
Translation assistance? ☐Yes ☐No If "Yes," what language?	**Translation assistance?** ☐Yes ☐No If "Yes," what language?
Date of Birth:	**Date of Birth:**
Last 4 digits of SSN:	**Last 4 digits of SSN:**
Race and Ethnicity (Check all that apply) ☐ American Indian, Alaska Native, or Indigenous ☐ Asian or Asian American ☐ Black, African American, or African ☐ Hispanic/Latina/o/e ☐ Middle Eastern or North African ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other/Addtl. Race or Ethnicity: _____ ☐ Don't know ☐ Prefer not to answer	**Race and Ethnicity (Check all that apply)** ☐ American Indian, Alaska Native, or Indigenous ☐ Asian or Asian American ☐ Black, African American, or African ☐ Hispanic/Latina/o/e ☐ Middle Eastern or North African ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other/Addtl. Race or Ethnicity: _____ ☐ Don't know ☐ Prefer not to answer
Gender (Check all that apply) ☐ Woman (Girl, if child) ☐ Man (Boy, if child) ☐ Culturally Specific Identity (e.g., Two-Spirit) ☐ Transgender ☐ Non-Binary ☐ Questioning ☐ Different Identity: _____ ☐ Don't know ☐ Prefer not to answer	**Gender (Check all that apply)** ☐ Woman (Girl, if child) ☐ Man (Boy, if child) ☐ Culturally Specific Identity (e.g., Two-Spirit) ☐ Transgender ☐ Non-Binary ☐ Questioning ☐ Different Identity: _____ ☐ Don't know ☐ Prefer not to answer
Sexual Orientation (Check all that apply) ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Questioning/Unsure ☐ Other: _____ ☐ Don't know ☐ Prefer not to answer	**Sexual Orientation (Check all that apply)** ☐ Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Questioning/Unsure ☐ Other: _____ ☐ Don't know ☐ Prefer not to answer

Working with an Intensive Case Management Program such as ACT? (If unsure, please choose "no") ☐ Yes ☐ No	**Working with an Intensive Case Management Program such as ACT? (If unsure, please choose "no")** ☐ Yes ☐ No
Covered by Health Insurance? ☐ Yes ☐ Don't know ☐ No ☐ Prefer not to answer **If yes, what type(s):** ☐ MEDICAID (Including OHP) ☐ MEDICARE ☐ Veteran's Health Administration (VHA) ☐ Employer-Provided Insurance ☐ COBRA ☐ Private Pay ☐ Indian Health Services ☐ Other: _____	**Covered by Health Insurance?** ☐ Yes ☐ Don't know ☐ No ☐ Prefer not to answer **If yes, what type(s):** ☐ MEDICAID (Including OHP) ☐ MEDICARE ☐ Veteran's Health Administration (VHA) ☐ Employer-Provided Insurance ☐ COBRA ☐ Private Pay ☐ Indian Health Services ☐ Other: _____
Have any of the conditions listed below? ☐ Yes ☐ Don't know ☐ No ☐ Prefer not to answer **If yes, what type(s)** ☐ Alcohol Use Disorder ☐ Drug Use Disorder ☐ Developmental Disability ☐ HIV/AIDS ☐ Mental Health Disorder ☐ Physical Disability ☐ Chronic Health Condition	**Have any of the conditions listed below?** ☐ Yes ☐ Don't know ☐ No ☐ Prefer not to answer **If yes, what type(s)** ☐ Alcohol Use Disorder ☐ Drug Use Disorder ☐ Developmental Disability ☐ HIV/AIDS ☐ Mental Health Disorder ☐ Physical Disability ☐ Chronic Health Condition
Monthly Income ☐ Yes ☐ Don't know ☐ No ☐ Prefer not to answer **If yes, what type(s) and how much per month?** ☐ Alimony: $_____ ☐ Child Support: $_____ ☐ Earned Income: $_____ ☐ General Assistance: $_____ *Continued on Page 3*	**Monthly Income** ☐ Yes ☐ Don't know ☐ No ☐ Prefer not to answer **If yes, what type(s) and how much per month?** ☐ Alimony: $_____ ☐ Child Support: $_____ ☐ Earned Income: $_____ ☐ General Assistance: $_____ *Continued on Page 3*

☐ Pension/Retirement: $_____ ☐ Private Disability Insurance: $_____ ☐ Social Security Retirement: $_____ ☐ SSDI: $_____ ☐ SSI: $_____ ☐ TANF: $_____ ☐ Unemployment: $_____ ☐ VA Non-Service Pension: $_____ ☐ VA Service-Rltd Comp: $_____ ☐ Other: $_____	☐ Pension/Retirement: $_____ ☐ Private Disability Insurance: $_____ ☐ Social Security Retirement: $_____ ☐ SSDI: $_____ ☐ SSI: $_____ ☐ TANF: $_____ ☐ Unemployment: $_____ ☐ VA Non-Service Pension: $_____ ☐ VA Service-Rltd Comp: $_____ ☐ Other: $_____
Do you receive any of the Non-Cash Benefits listed below? ☐ Yes ☐ Don't know ☐ No ☐ Prefer not to answer **If yes, what type(s)** ☐ Food Stamps/SNAP ☐ WIC Special Supplemental Nutrition Program ☐ TANF Child Care ☐ TANF Transportation Services ☐ Other Non-Cash Benefit	**Do you receive any of the Non-Cash Benefits listed below?** ☐ Yes ☐ Don't know ☐ No ☐ Prefer not to answer **If yes, what type(s)** ☐ Food Stamps/SNAP ☐ WIC Special Supplemental Nutrition Program ☐ TANF Child Care ☐ TANF Transportation Services ☐ Other Non-Cash Benefit