DATA FOR ALL CHILDREN

A separate form should be included for each household member.

FORM TYPE:

Update ☐ **Annual Review** ☐

CLIENT (name or other identifier)

UPDATE / ANNUAL REVIEW DATE (e.g., 08/24/2017)

		/			/				
Month			Day			Year			

HEALTH INSURANCE

Is the client currently covered by health insurance?

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused

[IF YES] Answer 'Yes' or 'No' for each health insurance source.

No	Yes	Source
☐	☐	Medicaid
☐	☐	Medicare
☐	☐	State Children's Health Insurance Program (or use local name)
☐	☐	Veteran's Administration (VA) Medical Services
☐	☐	Employer-Provided Health Insurance
☐	☐	Health insurance obtained through COBRA
☐	☐	Private Pay Health Insurance
☐	☐	State Health Insurance for Adults (or use local name)
☐	☐	Indian Health Services Program
☐	☐	Other If Yes, specify source: _____

----------Begin HIPAA Assessment----------

Pregnant?:

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused

Projected Due Date:

		/			/				
Month			Day			Year			

DISABLING CONDITION

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused

[IF YES] Answer 'Yes' or 'No' for each Disability Type.

No	Yes	Disability Type	[IF YES], expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?
☐	☐	Physical Disability	☐No ☐Yes ☐Doesn't Know ☐Refused
☐	☐	Developmental Disability	☐No ☐Yes ☐Doesn't Know ☐Refused
☐	☐	Chronic Health Condition	☐No ☐Yes ☐Doesn't Know ☐Refused
☐	☐	HIV/AIDS	☐No ☐Yes ☐Doesn't Know ☐Refused
☐	☐	Mental Health Problem	☐No ☐Yes ☐Doesn't Know ☐Refused
☐	☐	Substance Abuse: ☐Drug ☐Alcohol ☐Both Drug & Alcohol	☐No ☐Yes ☐Doesn't Know ☐Refused
☐	☐	Other If Yes, specify source: _____	☐No ☐Yes ☐Doesn't Know ☐Refused

----------*End HIPAA Assessment*----------

Last Grade Completed:

Received Vocational Training?

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused

Client / Guardian Signature:_____ **Date:**_____

Staff Signature:_____ **Date:**_____