Carroll County CoC Universal Data Assessment (Dependents Under 18 yrs)

Complete this form for the children/dependents in household.

Head of Household's Name: _____

List of Children / Dependents (Under 18 years of age)

First Name	Middle	Last Name	Relationship to Head of Household	Social Security Number	Date of Birth (Month / Day / Year)
1.				_____ - _____ - _____	_____ /_____ /_____

Gender (select all that apply)	☐ Female ☐ Male ☐ Transgender (M->F; F->M) ☐ Non-Binary ☐ Culturally Specific Identity (e.g. Two Spirit) ☐ Questioning ☐ Different Identity:_____ ☐ Don't Know ☐ Prefer Not to Answer
Race (select all that apply)	☐ American Indian, Alaska Native, or Indigenous ☐ Hispanic / Latina/e/o ☐ White ☐ Asian or Asian American ☐ Middle Eastern or North African ☐ Don't Know ☐ Black, African American, or African ☐ Native Hawaiian or Pacific Islander ☐ Prefer Not to Answer
Covered by Health Insurance? ☐ Yes ☐ No	☐ Medicaid ☐ Veteran's Administration Medical Services ☐ Private Pay Health Insurance ☐ Medicare ☐ Employer-Provided Health Insurance ☐ Indian Health Services Program ☐ State Children's Health Insurance Program ☐ Health Insurance through COBRA ☐ Other (specify): _____
Has Disabling Condition? ☐ Yes ☐ No	☐ Developmental ☐ Physical ☐ Chronic Health Condition ☐ Mental Health Disorder ☐ Drug Use Disorder ☐ Alcohol Use Disorder ☐ HIV/AIDS ☐ Don't Know ☐ Prefer Not to Answer
Highest Level of Education	☐ No Schooling ☐ < Grade 5 ☐ Grades 5-6 ☐ Grades 7-8 ☐ Grades 9-11 ☐ Grade 12, No diploma ☐ High School Diploma ☐ GED ☐ Prefer Not to Answer

First Name	Middle	Last Name	Relationship to Head of Household	Social Security Number	Date of Birth (Month / Day / Year)
2.				_____ - _____ - _____	_____ /_____ /_____

Gender (select all that apply)	☐ Female ☐ Male ☐ Transgender (M->F; F->M) ☐ Non-Binary ☐ Culturally Specific Identity (e.g. Two Spirit) ☐ Questioning ☐ Different Identity:_____ ☐ Don't Know ☐ Prefer Not to Answer
Race (select all that apply)	☐ American Indian, Alaska Native, or Indigenous ☐ Hispanic / Latina/e/o ☐ White ☐ Asian or Asian American ☐ Middle Eastern or North African ☐ Don't Know ☐ Black, African American, or African ☐ Native Hawaiian or Pacific Islander ☐ Prefer Not to Answer
Covered by Health Insurance? ☐ Yes ☐ No	☐ Medicaid ☐ Veteran's Administration Medical Services ☐ Private Pay Health Insurance ☐ Medicare ☐ Employer-Provided Health Insurance ☐ Indian Health Services Program ☐ State Children's Health Insurance Program ☐ Health Insurance through COBRA ☐ Other (specify): _____
Has Disabling Condition? ☐ Yes ☐ No	☐ Developmental ☐ Physical ☐ Chronic Health Condition ☐ Mental Health Disorder ☐ Drug Use Disorder ☐ Alcohol Use Disorder ☐ HIV/AIDS ☐ Don't Know ☐ Prefer Not to Answer
Highest Level of Education	☐ No Schooling ☐ < Grade 5 ☐ Grades 5-6 ☐ Grades 7-8 ☐ Grades 9-11 ☐ Grade 12, No diploma ☐ High School Diploma ☐ GED ☐ Prefer Not to Answer

Carroll County CoC Universal Data Assessment (Dependents Under 18 yrs)

Complete this form for the children/dependents in household.

Head of Household's Name: _____

First Name	Middle	Last Name	Relationship to Head of Household	Social Security Number	Date of Birth (Month / Day / Year)
3.				_____ - _____ - _____	_____ /_____ /_____
Gender (select all that apply)	☐ Female ☐ Male ☐ Transgender (M->F; F->M) ☐ Non-Binary ☐ Culturally Specific Identity (e.g. Two Spirit) ☐ Questioning ☐ Different Identity:_____ ☐ Don't Know ☐ Prefer Not to Answer				
Race (select all that apply)	☐ American Indian, Alaska Native, or Indigenous ☐ Hispanic / Latina/e/o ☐ White ☐ Asian or Asian American ☐ Middle Eastern or North African ☐ Don't Know ☐ Black, African American, or African ☐ Native Hawaiian or Pacific Islander ☐ Prefer Not to Answer				
Covered by Health Insurance? ☐ Yes ☐ No	☐ Medicaid ☐ Veteran's Administration Medical Services ☐ Private Pay Health Insurance ☐ Medicare ☐ Employer-Provided Health Insurance ☐ Indian Health Services Program ☐ State Children's Health Insurance Program ☐ Health Insurance through COBRA ☐ Other (specify): _____				
Has Disabling Condition? ☐ Yes ☐ No	☐ Developmental ☐ Physical ☐ Chronic Health Condition ☐ Mental Health Disorder ☐ Drug Use Disorder ☐ Alcohol Use Disorder ☐ HIV/AIDS ☐ Don't Know ☐ Prefer Not to Answer				
Highest Level of Education	☐ No Schooling ☐ < Grade 5 ☐ Grades 5-6 ☐ Grades 7-8 ☐ Grades 9-11 ☐ Grade 12, No diploma ☐ High School Diploma ☐ GED ☐ Prefer Not to Answer				

First Name	Middle	Last Name	Relationship to Head of Household	Social Security Number	Date of Birth (Month / Day / Year)
4.				_____ - _____ - _____	_____ /_____ /_____
Gender (select all that apply)	☐ Female ☐ Male ☐ Transgender (M->F; F->M) ☐ Non-Binary ☐ Culturally Specific Identity (e.g. Two Spirit) ☐ Questioning ☐ Different Identity:_____ ☐ Don't Know ☐ Prefer Not to Answer				
Race (select all that apply)	☐ American Indian, Alaska Native, or Indigenous ☐ Hispanic / Latina/e/o ☐ White ☐ Asian or Asian American ☐ Middle Eastern or North African ☐ Don't Know ☐ Black, African American, or African ☐ Native Hawaiian or Pacific Islander ☐ Prefer Not to Answer				
Covered by Health Insurance? ☐ Yes ☐ No	☐ Medicaid ☐ Veteran's Administration Medical Services ☐ Private Pay Health Insurance ☐ Medicare ☐ Employer-Provided Health Insurance ☐ Indian Health Services Program ☐ State Children's Health Insurance Program ☐ Health Insurance through COBRA ☐ Other (specify): _____				
Has Disabling Condition? ☐ Yes ☐ No	☐ Developmental ☐ Physical ☐ Chronic Health Condition ☐ Mental Health Disorder ☐ Drug Use Disorder ☐ Alcohol Use Disorder ☐ HIV/AIDS ☐ Don't Know ☐ Prefer Not to Answer				
Highest Level of Education	☐ No Schooling ☐ < Grade 5 ☐ Grades 5-6 ☐ Grades 7-8 ☐ Grades 9-11 ☐ Grade 12, No diploma ☐ High School Diploma ☐ GED ☐ Prefer Not to Answer				