

**Add Family Member - Continued**

| First Name*:  | Last Name*: | Birth Date*:   | Age:  | Gender*:   |
|---|-------------|--|---|--|
| 6)  |             |  |   |  |
| <b>Relationship to Head of Household*</b><br><input type="checkbox"/> Spouse <input type="checkbox"/> Other Relative<br><input type="checkbox"/> Child <input type="checkbox"/> Other Non-Relative<br><input type="checkbox"/> Step-Child <input type="checkbox"/> Unknown<br><input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild<br><input type="checkbox"/> Guardian <input type="checkbox"/> Foster-Child |             | <b>Social Security#*:</b><br><input type="checkbox"/> Full <input type="checkbox"/> Partial<br><input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Refused<br><input type="checkbox"/> Data Not Collected | <input type="checkbox"/> Full DOB<br><input type="checkbox"/> Partial (MM/YY)<br><input type="checkbox"/> Partial (DD/YY)<br><input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client refused<br><input type="checkbox"/> Data Not Collected | <input type="checkbox"/> Male<br><input type="checkbox"/> Female<br><input type="checkbox"/> Trans M-F<br><input type="checkbox"/> Trans F-M<br><input type="checkbox"/> Refused<br><input type="checkbox"/> Other |

| First Name*:  | Last Name*: | Birth Date*:   | Age:  | Gender*:   |
|---|-------------|--|---|--|
| 7)  |             |  |   |  |
| <b>Relationship to Head of Household*</b><br><input type="checkbox"/> Spouse <input type="checkbox"/> Other Relative<br><input type="checkbox"/> Child <input type="checkbox"/> Other Non-Relative<br><input type="checkbox"/> Step-Child <input type="checkbox"/> Unknown<br><input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild<br><input type="checkbox"/> Guardian <input type="checkbox"/> Foster-Child |             | <b>Social Security#*:</b><br><input type="checkbox"/> Full <input type="checkbox"/> Partial<br><input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Refused<br><input type="checkbox"/> Data Not Collected | <input type="checkbox"/> Full DOB<br><input type="checkbox"/> Partial (MM/YY)<br><input type="checkbox"/> Partial (DD/YY)<br><input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client refused<br><input type="checkbox"/> Data Not Collected | <input type="checkbox"/> Male<br><input type="checkbox"/> Female<br><input type="checkbox"/> Trans M-F<br><input type="checkbox"/> Trans F-M<br><input type="checkbox"/> Refused<br><input type="checkbox"/> Other |

| First Name*:  | Last Name*: | Birth Date*:   | Age:  | Gender*:   |
|---|-------------|--|---|--|
| 8)  |             |  |   |  |
| <b>Relationship to Head of Household*</b><br><input type="checkbox"/> Spouse <input type="checkbox"/> Other Relative<br><input type="checkbox"/> Child <input type="checkbox"/> Other Non-Relative<br><input type="checkbox"/> Step-Child <input type="checkbox"/> Unknown<br><input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild<br><input type="checkbox"/> Guardian <input type="checkbox"/> Foster-Child |             | <b>Social Security#*:</b><br><input type="checkbox"/> Full <input type="checkbox"/> Partial<br><input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Refused<br><input type="checkbox"/> Data Not Collected | <input type="checkbox"/> Full DOB<br><input type="checkbox"/> Partial (MM/YY)<br><input type="checkbox"/> Partial (DD/YY)<br><input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client refused<br><input type="checkbox"/> Data Not Collected | <input type="checkbox"/> Male<br><input type="checkbox"/> Female<br><input type="checkbox"/> Trans M-F<br><input type="checkbox"/> Trans F-M<br><input type="checkbox"/> Refused<br><input type="checkbox"/> Other |

| First Name*:  | Last Name*: | Birth Date*:   | Age:  | Gender*:   |
|---|-------------|--|---|--|
| 9)  |             |  |   |  |
| <b>Relationship to Head of Household*</b><br><input type="checkbox"/> Spouse <input type="checkbox"/> Other Relative<br><input type="checkbox"/> Child <input type="checkbox"/> Other Non-Relative<br><input type="checkbox"/> Step-Child <input type="checkbox"/> Unknown<br><input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild<br><input type="checkbox"/> Guardian <input type="checkbox"/> Foster-Child |             | <b>Social Security#*:</b><br><input type="checkbox"/> Full <input type="checkbox"/> Partial<br><input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Refused<br><input type="checkbox"/> Data Not Collected | <input type="checkbox"/> Full DOB<br><input type="checkbox"/> Partial (MM/YY)<br><input type="checkbox"/> Partial (DD/YY)<br><input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client refused<br><input type="checkbox"/> Data Not Collected | <input type="checkbox"/> Male<br><input type="checkbox"/> Female<br><input type="checkbox"/> Trans M-F<br><input type="checkbox"/> Trans F-M<br><input type="checkbox"/> Refused<br><input type="checkbox"/> Other |

| First Name*:  | Last Name*: | Birth Date*:   | Age:  | Gender*:   |
|---|-------------|--|---|--|
| 10)   |             |  |   |  |
| <b>Relationship to Head of Household*</b><br><input type="checkbox"/> Spouse <input type="checkbox"/> Other Relative<br><input type="checkbox"/> Child <input type="checkbox"/> Other Non-Relative<br><input type="checkbox"/> Step-Child <input type="checkbox"/> Unknown<br><input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild<br><input type="checkbox"/> Guardian <input type="checkbox"/> Foster-Child |             | <b>Social Security#*:</b><br><input type="checkbox"/> Full <input type="checkbox"/> Partial<br><input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Refused<br><input type="checkbox"/> Data Not Collected | <input type="checkbox"/> Full DOB<br><input type="checkbox"/> Partial (MM/YY)<br><input type="checkbox"/> Partial (DD/YY)<br><input type="checkbox"/> Client doesn't know<br><input type="checkbox"/> Client refused<br><input type="checkbox"/> Data Not Collected | <input type="checkbox"/> Male<br><input type="checkbox"/> Female<br><input type="checkbox"/> Trans M-F<br><input type="checkbox"/> Trans F-M<br><input type="checkbox"/> Refused<br><input type="checkbox"/> Other |