

D2. ADULT INFORMATION: (Required for each person 18 years or older in household)				
<b>3rd Adult Household Member's Name:</b>			<b>4th Adult Household Member's Name:</b>	
What school grade did you last complete?			What school grade did you last complete?	
Diploma? <input type="checkbox"/> Yes <input type="checkbox"/> No      GED? <input type="checkbox"/> Yes <input type="checkbox"/> No			Diploma? <input type="checkbox"/> Yes <input type="checkbox"/> No      GED? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you in school or working on a degree? <input type="checkbox"/> Yes <input type="checkbox"/> No      If yes, what school?			Are you in school or working on a degree? <input type="checkbox"/> Yes <input type="checkbox"/> No      If yes, what school?	
<b>Work Status: (check one)</b> <input type="checkbox"/> Employed Full-Time <input type="checkbox"/> Employed Part-Time <input type="checkbox"/> Migrant Seasonal Farm Worker <input type="checkbox"/> Unemployed (Short-term) <input type="checkbox"/> Unemployed (Long-term) <input type="checkbox"/> Unemployed (Not in Labor Force) <input type="checkbox"/> Retired <input type="checkbox"/> Unknown/Not Reported			<b>Work Status: (check one)</b> <input type="checkbox"/> Employed Full-Time <input type="checkbox"/> Employed Part-Time <input type="checkbox"/> Migrant Seasonal Farm Worker <input type="checkbox"/> Unemployed (Short-term) <input type="checkbox"/> Unemployed (Long-term) <input type="checkbox"/> Unemployed (Not in Labor Force) <input type="checkbox"/> Retired <input type="checkbox"/> Unknown/Not Reported	
<b>Health Insurance: (check all that apply)</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private Health Insurance <input type="checkbox"/> Nevada Check-Up <input type="checkbox"/> Direct-Purchase <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Military Healthcare (VA) <input type="checkbox"/> Employment Based <input type="checkbox"/> Tribal Insurance <input type="checkbox"/> No Health Insurance <input type="checkbox"/> Unknown/Not Reported			<b>Health Insurance: (check all that apply)</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private Health Insurance <input type="checkbox"/> Nevada Check-Up <input type="checkbox"/> Direct-Purchase <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Military Healthcare (VA) <input type="checkbox"/> Employment Based <input type="checkbox"/> Tribal Insurance <input type="checkbox"/> No Health Insurance <input type="checkbox"/> Unknown/Not Reported	
<b>Check ONE for each category:</b>  Do you have a disabling condition? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused Do you have a physical disability? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused -Is it long term? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused Do you have a developmental disability? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused Do you have a chronic health condition? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused Do you have HIV/AIDS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused Do you have a mental health problem? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused Do you have a substance abuse problem? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused Are you a domestic violence victim/survivor? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused			<b>Check ONE for each category:</b>  Do you have a disabling condition? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused Do you have a physical disability? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused -Is it long term? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused Do you have a developmental disability? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused Do you have a chronic health condition? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused Do you have HIV/AIDS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused Do you have a mental health problem? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused Do you have a substance abuse problem? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused Are you a domestic violence victim/survivor? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	
Have you been convicted of a misdemeanor or felony? <input type="checkbox"/> Yes <input type="checkbox"/> No			Have you been convicted of a misdemeanor or felony? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you required to register? <input type="checkbox"/> Yes <input type="checkbox"/> No			Are you required to register? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Explain conviction and date:			Explain conviction and date:	
List last 3 years arrests:			List last 3 years arrests:	

\* If you have more than 2 adults in household, please ask a staff member for an additional adult information sheet.