

Additional Household Members

Applicant Name: _____

Household Member # _____

First Name		Middle Name or Initial		Last Name	
Relationship to Applicant <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Partner <input type="checkbox"/> Adult Child <input type="checkbox"/> Foster Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Grandparent <input type="checkbox"/> Parent <input type="checkbox"/> Not Related <input type="checkbox"/> Other: _____					
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		Date of Birth		Social Security Number	
Hispanic/Latino? <input type="checkbox"/> No <input type="checkbox"/> Yes		Race (please select one) <input type="checkbox"/> White/Caucasian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian		<input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other: _____	
Citizenship: <input type="checkbox"/> U.S. Born/Naturalized <input type="checkbox"/> Eligible Immigrant <input type="checkbox"/> Non-Citizen		Veteran or Active Military <input type="checkbox"/> Veteran <input type="checkbox"/> Active Military <input type="checkbox"/> No Military History		Do They Have a Disability? <input type="checkbox"/> No <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Speech <input type="checkbox"/> Learning <input type="checkbox"/> Orthopedic <input type="checkbox"/> Other	
Education, if Over 18					
<input type="checkbox"/> K-8 th Non-Grad <input type="checkbox"/> 9-12 th Non-Grad		<input type="checkbox"/> High-School Grad <input type="checkbox"/> GED/HISET Grad		<input type="checkbox"/> Some College <input type="checkbox"/> 2- or 4-Year College Grad <input type="checkbox"/> Master's Degree or Higher	
Employment, if Over 18		Source(s) of Income:			
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time Length of Employment: _____		<input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired		<input type="checkbox"/> Pension <input type="checkbox"/> SSI <input type="checkbox"/> SSDI <input type="checkbox"/> Social Security <input type="checkbox"/> Alimony <input type="checkbox"/> Child Support <input type="checkbox"/> TANF/Families First <input type="checkbox"/> VA Benefits	
How Are They Paid?		Health Insurance?			
<input type="checkbox"/> Weekly <input type="checkbox"/> Every Two Weeks		<input type="checkbox"/> Twice a Month <input type="checkbox"/> Monthly		<input type="checkbox"/> No <input type="checkbox"/> Direct Purchase <input type="checkbox"/> Employment Based <input type="checkbox"/> Medicare <input type="checkbox"/> TennCare/Medicaid <input type="checkbox"/> Military <input type="checkbox"/> Other	

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Citizenship: <input type="checkbox"/> U.S. Born/Naturalized <input type="checkbox"/> Eligible Immigrant <input type="checkbox"/> Non-Citizen		Veteran or Active Military <input type="checkbox"/> Veteran <input type="checkbox"/> Active Military <input type="checkbox"/> No Military History		Do They Have a Disability? <input type="checkbox"/> No <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Speech <input type="checkbox"/> Learning <input type="checkbox"/> Orthopedic <input type="checkbox"/> Other	
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