ESM Client ID:

Provider ID:

Intake Form Standard

▶ ***ESM Release of Information***: ☐ Yes ☐ No

▶ Enrollment Date: / /
mm dd yyyy

ALL QUESTIONS MARKED WITH A ▶ MUST BE COMPLETED.

1. First Name: **Middle Initial:** **Last Name:** **Suffix:**

▶ **2. Highest Grade Completed:**

☐ Not of school age	☐ High school diploma/GED	☐ College degree or higher	☐ No formal education
☐ Some schooling, no high school	☐ Some college	☐ Other credential (degree, certificate)	☐ Unknown
☐ Some high school	☐ Associates degree		

▶ **3. Gender:** Male ☐ Female ☐ Transgender ☐

▶ **4. Birth Date:** / /
mm dd yyyy

▶ **5. SSN:** *If client refuses to give SSN or it is unknown, enter 999-99-9999*

PERSONAL INFORMATION>ADDRESS

▶ **6a. Address Type:** Home ☐ Near Homeless ☐ Homeless ☐ *See Job Aid in the Intake Manual to determine Homeless vs. non-Homeless!*

If Address Type is "Homeless", only enter the city/town and zip code where client is usually homeless. ***Do not use the Program's city/town/zip.***

Street Address: Unit:

▶ City/Town: ▶ State: ▶ Zip code:

▶ **6b. Is this your Primary Address?** Yes ☒

ALTERNATE NAME Section

If client has an alternate name, complete the following:

7a. First Name: **Middle Initial:** **Last Name:**

7b. Name Type: Alias ☐ Nickname ☐ Known by ☐ Married Name ☐ Maiden Name ☐ Name at Birth ☐ Prior Marriage Name ☐

DEMOGRAPHICS>CULTURAL CHARACTERISTICS

▶ **8a. Are you Spanish/ Hispanic/Latino?** Yes ☐ No ☐

If 'yes' to Question 8a, complete Question 8b. ***If 'no' to Question 8a, go to Question 9***

8b. Which of the following ethnicities best describes you?

______ Central American ______ Mexican, Mexican American, Chicano ______ South American
______ Cuban ______ Puerto Rican ______ Unknown
______ Dominican ______ Salvadoran ______ Other, specify ____________________

If 'no' to Question 8a, Select one from below

9. What is your primary Ethnicity/Ancestry? *(select one only)*

______ African	______ Chinese	______ Latin American Indian
______ African American	______ Eastern European	______ Middle Eastern
______ American	______ European	______ Portuguese
______ Asian Indian	______ Filipino	______ Russian
______ Brazilian	______ Haitian	______ Thai
______ Cambodian	______ Japanese	______ Vietnamese
______ Cape Verdean	______ Korean	______ Unknown
______ Caribbean Islander	______ Laotian	______ Other ,specify ______

▶ **10. What is your race**? *(check all that apply)*

______ American Indian/Alaskan Indian
______ Asian
______ Black, African American
______ Native Hawaiian or Pacific Islander
______ White
______ Other, specify: ______________________
______ Unknown
______ Refused

▶ **11. In what language do you prefer to read or discuss health related materials?**

______ American Sign Language
______ Cambodian (Khmer)
______ Cape Verdean Creole
______ Chinese
______ English
______ Haitian Creole
______ Hmong
______ Korean
______ Laotian
______ Portuguese
______ Russian
______ Spanish
______ Vietnamese
______ Other, specify ______________________

HOUSEHOLD CHARACTERISTICS Section

▶ **12. Number of Adults in Household:** *(if client is Homeless, enter 1)*

13. Number of Children Living in Household *(children under 19)*: *(children currently living with the client whether or not related)*

▶ **14a. Client Income: $**

14b. Income Frequency: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annually

15. Source of Income: *(Check all that apply)*

______ Wages/Salary
______ Child Support
______ Alimony
______ Disability
______ Disability - SSI
______ Disability - SSIDI
______ Veterans Disability Payment
______ Private Disability Payment
______ Public Assistance - TANF
______ Public Assistance - General
______ Unemployment Compensation
______ Workers Compensation
______ Retirement - Social Security
______ Retirement/Pension - Private
______ Veterans Pension
______ Non-employment Cash Income
______ None
______ Other

16. Received Income Verification: ☐

▶ **17. Marital Status:** ☐ Never Married ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Significant Partnership Rlat.

INSURANCE Section *(Data Entry: To get to Insurance section, return to Face Sheet and select Insurance link on left side of screen.)*

▶ **18. Insurance Type:**

☐ **Uninsured**
☐ **MC** (Medicaid / MassHealth / MBHP
☐ **MP** (Medicare –Over 65-some disabled)
☐ **VA** Veterans Administration
☐ **HM** Private HMO – through employment or client pay
☐ **CI** Private Insurance – through employment or client pay with no subsidy
☐ **OT** Other - Includes State subsidy – ConnectCare / Health Safety Net

▶ **Insurance Company Name**
Not required if uninsured:

Policy Number:
*If Insurance Type is **MC**, the MassHealth Number, which begins with "100", must be entered.*

Data Entry:
If entering a New insurance record, enter the Enrollment Date as the Insurance Effective Date.
If existing client with new insurance, end date previous insurance record with day before this Enrollment Date
If existing client and the insurance has Not Changed since the client's last enrollment (whether or not at your program), simply hit SAVE!!!

▶ **19. Is this your Primary Insurance?** Yes ☐ No ☐

If the client has additional insurance coverage, complete the following. If not, intake is complete.

20. Additional Insurance Type: *Note: Uninsured is not an option under additional insurance.*

☐ **MC** Medicaid / MassHealth / MBHP
☐ **MP** Medicare –Over 65-some disabled
☐ **VA** Veterans Administration
☐ **HM** –Private HMO – through employment or client pay
☐ **CI** Private Insurance – through employment or client pay with no subsidy)
☐ **OT** Other - Includes State subsidy – ConnectCare / Health Safety Net)

Insurance Company Name:

Policy Number:
*If Insurance Type is **MC**, the MassHealth Number, which begins with "100", must be entered.*