|  |
| --- |
|  **ESM Client ID:** Massachusetts Department of Public Health Logo Intake Form*⯈****ESM Release of Information***: Yes No Standard **Provider ID:**⯈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 byMarried Name Maiden Name Name at BirthPrior 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 |
| **Client Demographics *Intake Form*** |  | 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 |  | Native Hawaiian or Pacific Islander |  | Unknown |
|  |  | Asian |  | White |  | Refused |
|  |  | Black, African American |  | Other, specify: |  |  |
|  |  |  |  |  |  |  |
| ⯈ | **11. In what language do you prefer to read or discuss health related materials?** |
|  |  | American Sign Language |  | Haitian Creole |  | Russian |
|  |  | Cambodian (Khmer) |  | Hmong |  | Spanish |
|  |  | Cape Verdean Creole |  | Korean |  | Vietnamese |
|  |  | Chinese |  | Laotian  |  | Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | English |  | Portuguese |  |  |  |
|  |  |  |  |  |  |  |

**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 |  | Veterans Disability Payment |  | Retirement - Social Security |
|  | Child Support |  | Private Disability Payment |  | Retirement/Pension - Private |
|  | Alimony |  | Public Assistance - TANF |  | Veterans Pension |
|  | Disability |  | Public Assistance - General |  | Non-employment Cash Income |
|  | Disability - SSI |  | Unemployment Compensation |  | None |
|  | Disability - SSIDI |  | Workers Compensation |  | 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.* |