|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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.* | | | | |