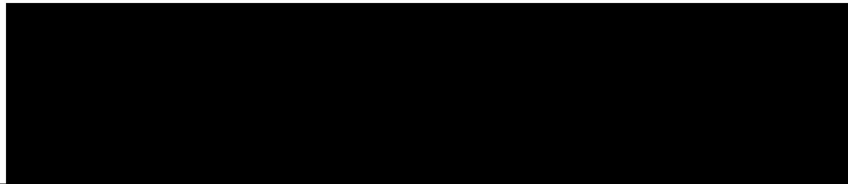

# CLIENT INTAKE FORM

Please check appropriate boxes. If asked a question, fill in information on designated space.
All words that are bold are required information.

**Source of Referral:** ☐ Self ☐ Health Department (County) ________ ☐ Friend ☐ Other _________________

**Jurisdiction of referring agency**: ☐ DC ☐ MD ☐ VA ☐ Other:_________

Date of Initial Intake ______________

Revised Date: ___________________

Reviewed Date(s): ________________________________

## ***Client Identification***

**Last name** _______________________________

**First name** __________________ MI _______

**Date of birth** ____________ Age ______

**SSN** _________________**Medicaid #** _______________

## ***Address information*** (provide current address)

Street address: _________________________________

City _______________ State ____ Zip _________

Phone _______________ email _________________

Is this your mailing address? ☐ Yes ☐ No

If no, please provide other address:

Street address: _________________________________

City _______________ State ____ Zip _________

***Confidentiality Issues***

Can we call ? ☐ Yes ☐ No
Identify as GBMS? ☐ Yes ☐ No
Send mail? ☐ Yes ☐ No
Can we email? ☐ Yes ☐ No
Special instructions: __________________________

## ***Personal Information*** (check one only)

**Sex:** ☐ Male ☐ Female ☐ Transgender M to F ☐ Transgender F to M

**Ethnicity:** ☐ Hispanic ☐ Non-Hispanic

**Race:** ☐ White ☐ Black/African American ☐ Asian ☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ More than one race

Nationality (country of origin) ____________________

Sexual orientation

☐ Heterosexual ☐ Bisexual
☐ Homosexual ☐ Does not apply, child
☐ Unknown/unreported

Marital status

☐ Single ☐ Married
☐ Separated ☐ Divorced
☐ Co-habitating ☐ Widowed
☐ Other ☐ Unknown

Are You a United States Veteran?
☐ Yes ☐ No

**OFFICE USE ONLY: ALL INFORMATION ON PAGE VERIFIED & UPDATED**
***1ST*** **Review Date:_____________ 2nd Review Date:________________ GBMS STAFF:____**

## *Housing/family/income information*

Housing status:

- ☐ Lives alone
- ☐ W/ spouse or partner
- ☐ W/ spouse & children
- ☐ W/ dependent children
- ☐ With non-dependent children
- ☐ W/ parents or guardian & dependent children
- ☐ W/ parents or guardian only
- ☐ W/ other relatives
- ☐ W/ contributing non-relative room mates
- ☐ W/ non-contributing, non-relative room mates
- ☐ Lives in shelter
- ☐ Homeless, in street
- ☐ Lives in foster care
- ☐ Lives in chronic care facility

Needs Identified: ☐ None ☐____________________
Plan: ________________________________________

Are you head of household? ☐ Yes ☐ No

Client family status

- ☐ Self ☐ Mother ☐ Father
- ☐ Sibling ☐ Grandparent ☐ other adult relative
- ☐ Other non-related adult ☐ caregiver
- ☐ Child <21, single child home
- ☐ Child <21, multi child home

Number of children (<18) in household ________

Total persons in household _______

## *Social Benefits and Entitlements*

Your entitlements: (Please check all that apply)

- ☐ TANF ☐ SSDI ☐ SSI
- ☐ Food stamps ☐ WIC ☐ Disability
- ☐ Unemployment ☐ Veteran ☐ GPA/GR
- ☐ Tenant Asst ☐ ADAP ☐ HOPWA
- ☐ Emergency ☐ Shelter +Care
- ☐ DC Housing ☐ Child Protective Services
- ☐ Other ☐ None

## *Insurance status*

Type of medical insurance (Please check all that apply)

- ☐ Private ☐ Medicare
- ☐ Medicaid ☐ Other public insurance
- ☐ VA ☐ None

Name of insurance company ________________________

Agent address ____________________________________

City ___________________ State ____ Zip _______

Phone _________________ email ________________

Co-pay amount ($) _________________

## *Language/Education Information*

Client's spoken language ___________________

Client's written language ___________________

Caregiver spoken language ___________________

Caregiver written language ___________________

**OFFICE USE ONLY: ALL INFORMATION ON PAGE VERIFIED & UPDATED**
**1ST Review Date:______________ 2nd Review Date:__________________ GBMS STAFF:____**

Client's education:

☐ None ☐ Unknown

☐ Grades 0-6 ☐ Grades 7-9

☐ Grades 10-12 ☐ 2 year college

☐ 4 yr college ☐ Postgraduate

☐ Professional ☐ Technical

## *Employment Information*

Primary job ☐ Full time ☐ Part time

Date of employment ____________________

Company name _______________________________

Address _______________________________

City ______________ State _____ Zip ________

Phone ______________ email __________________

Job title: ____________________________________

Second job (if any) ☐ Full time ☐ Part time

Date of employment ____________________

Company name _______________________________

Address _______________________________

City ______________ State ____ Zip _______

Phone ______________ email __________________

Job title: ____________________________________

## Income:

Annual Individual Income___________________

Annual Household Income ___________________

_____ 100% - 200% of federal poverty level

_____ 200% - 300% of federal poverty level

_____ 300% or > than federal poverty level



## *Contact Information / Social Support*

Please check ☐ if contact has to be done with Discretion or prior permission in case of emergency or any eventuality.

Emergency contact:

Contact name ________________________________

Address _____________________________________

City ________________ State _____ Zip _______

Phone ___________________ email ____________

Relation to Client: _____________________________

## *Special needs/other information*

Please check all that apply:

☐ Hearing impaired ☐ Visually impaired

☐ Physically impaired ☐ Wheelchair bound

☐ Developmentally disabled

☐ Recently released from incarceration

☐ Recently incarcerated

☐ Chronically mentally ill

☐ Other need ________________________

☐ None

## *Legal Information*

Has client ever been convicted of criminal or civil charges?
☐ Yes ☐ No
Does client have any court cases pending? ☐ Yes ☐ No
Is client on probation or parole? ☐ Yes ☐ No

### *Assessment*

☐ Client needs assistance with legal issues. (e.g. Health Care Proxy, Will, Living Will, Power of Attorney, Immigration, Guardianship, Other)
☐ Intervention is needed.
☐ Client needs assistance with legal issues within the next month.
☐ Client may need legal assistance in the future.
☐ Client has no legal needs at this time.

STAFF SIGNATURE:______________________
CLIENT SIGNATURE:_____________________
DATE(S) REVIEWED:_____________________
______________________