



## Intake and Eligibility Form

### Section 1: Please complete the following information.

|   |                         |
|---|-------------------------|
| Name:   | Today's Date:           |
| Home address:   | Social Security Number: |
| Home phone:   | Cell phone:             |
| Email: (for appointment reminds, health-related topics, and other items related to your care) |                         |
| How were you referred to Grace?   |                         |

### Section 2: Patient Profile

|  |  |
|--|--|
| Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male  | Date of Birth:   |
| Marital Status<br><input type="checkbox"/> Single<br><input type="checkbox"/> Married<br><input type="checkbox"/> Separated<br><input type="checkbox"/> Divorced<br><input type="checkbox"/> Widowed   | What is the highest level of education you completed?<br><input type="checkbox"/> No school completed<br><input type="checkbox"/> Elementary School<br><input type="checkbox"/> High School<br><input type="checkbox"/> GED<br><input type="checkbox"/> College/University   |
| Are you a veteran?<br><input type="checkbox"/> Yes<br><input type="checkbox"/> No  | Are you currently a student?<br><input type="checkbox"/> Yes, part-time<br><input type="checkbox"/> Yes, full-time<br><input type="checkbox"/> No  |
| Race:<br><input type="checkbox"/> White<br><input type="checkbox"/> Black/African American<br><input type="checkbox"/> Asian<br><input type="checkbox"/> Native Hawaiian<br><input type="checkbox"/> Other Pacific Islander<br><input type="checkbox"/> American Indian/Alaskan Native<br><input type="checkbox"/> Other | Where do you currently live?<br><input type="checkbox"/> Own a home<br><input type="checkbox"/> Rent an apartment/house<br><input type="checkbox"/> Staying with friends/relatives<br><input type="checkbox"/> Shelter<br><input type="checkbox"/> Transitional housing<br><input type="checkbox"/> Staying on the street, in car, in woods, etc |
| Ethnicity:<br><input type="checkbox"/> Not Hispanic/Latino<br><input type="checkbox"/> Hispanic/Latino   | Are you a member of a religious organization (e.g. church, temple, etc)? <input type="checkbox"/> Yes <input type="checkbox"/> No<br><br>If so, which one?   |



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### Section 3: Family Information

Please name the people in your immediate family who you would like to be a patient and receive care at Grace? Do **not** list family members who will not be patients here.

| Family Member's Name | Relationship | Birth Date | Social Security Number | Name of school (if student) |
|----------------------|--------------|------------|------------------------|-----------------------------|
|                      |              |            |                        |                             |
|                      |              |            |                        |                             |
|                      |              |            |                        |                             |
|                      |              |            |                        |                             |
|                      |              |            |                        |                             |

### Emergency Contact Information.

| Emergency Contact Name | Relationship | Address | Phone |
|------------------------|--------------|---------|-------|
|                        |              |         |       |

### Section 4: Employment

|  |   |
|--|---|
| Are you currently working?<br><input type="checkbox"/> Yes, full-time<br><input type="checkbox"/> Yes, part-time<br><input type="checkbox"/> No, last date of work was _____   | Who is your current employer? If you are not currently working, who was your most recent employer?  |
| Are you a <u>migrant agricultural worker</u> ? (an individual whose principal employment is in agriculture on a seasonal basis and who establishes a temporary home for the purposes of such employment)<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Are you a <u>seasonal agricultural worker</u> ? (an individual whose principal employment is in agriculture on a seasonal basis and who <u>does not</u> establish a temporary home for purposes of employment.)<br><input type="checkbox"/> Yes <input type="checkbox"/> No |

Signature: I certify by my signature that, to the best of my knowledge, the above information is true and complete.  
 Signed: \_\_\_\_\_ Date \_\_\_\_\_



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### Section 5: Health and Health Care History

|   |
|---|
| <p>Is there a particular doctor's office, clinic, health center, or other place that you usually go if you are sick or need advice about your health?      <input type="checkbox"/> Yes      <input type="checkbox"/> No</p> <p>If no, have you ever been a regular patient at a clinic, health center, or doctor's office?      <input type="checkbox"/> Yes      <input type="checkbox"/> No</p> <p>When (what year) were you last seen as a patient there? _____</p>   |
| <p>Where would you typically go to get care for a sudden medical problem such as a sinus infection or a badly twisted ankle? Check ONLY ONE.</p> <p><input type="checkbox"/> Health Clinic      <input type="checkbox"/> My regular doctor      <input type="checkbox"/> Emergency Room</p> <p><input type="checkbox"/> Urgent care office (like Centra Care or Minute Clinic)      <input type="checkbox"/> Would not get care</p> <p><input type="checkbox"/> Other (please describe)</p>   |
| <p>Where would you typically go to get checked for chronic issues such as diabetes, high blood pressure, heart disease, asthma or other chronic illness? Check ONLY ONE.</p> <p><input type="checkbox"/> I do not have a chronic illness</p> <p><input type="checkbox"/> Health Clinic      <input type="checkbox"/> My regular doctor      <input type="checkbox"/> Emergency Room</p> <p><input type="checkbox"/> Urgent care office (like Centra Care or Minute Clinic)      <input type="checkbox"/> Would not get care</p> <p><input type="checkbox"/> Other (please describe)</p> |
| <p>Where would you typically go to get checkups, physicals, shots/immunizations, or other preventive care? Check ONLY ONE.</p> <p><input type="checkbox"/> Health Clinic      <input type="checkbox"/> My regular doctor      <input type="checkbox"/> Emergency Room</p> <p><input type="checkbox"/> Urgent care office (like Centra Care or Minute Clinic)      <input type="checkbox"/> Would not get preventive care</p> <p><input type="checkbox"/> Other (please describe)</p>  |
| <p>In the last year, have you been to the Emergency Room:      <input type="checkbox"/> Yes      <input type="checkbox"/> No</p> <p>In the last year, have you been admitted to a hospital for one or more nights?      <input type="checkbox"/> Yes      <input type="checkbox"/> No</p> <p>NOTE: If you can find your discharge papers from the hospital/ER visit, <b>please bring them to your first appointment.</b> That will help your nurse and doctor understand better what happened and give you better care.</p>   |

### For Grace Medical Home Only

|   |  |
|---|--|
| <p>Proof of legal residency type:</p>   | <p>Best served in language other than English?</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>                        |
| <p>Employment status verification type:</p>   | <p>Meets income eligibility based on DOH form:</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>                        |
| <p>Eligible to be patient?</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p> | <p>First medical appointment scheduled?</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p> <p>Appointment date/time:</p> |