Health Care for the Homeless

INFORMATION RESOURCE CENTER

888/429-3300 • Fax 518/439-7612

#12. INTAKE FORMS

Adult problem list (*WES 2*)
Brief intake for case management services (*TER 1R*)
Case management intake (*ANC 1*)
Intake form (*BIR 4*)
Intake form (*COM 1*)
Intake form (*FAM 1*)
Intake form (*HCLA 5*)
Intake form (*LOS 2*)
Intake form (*LOS 2R*)
Intake form (*TER 1*)
Intake/encounter form (*SEA 1*)
Initial demographic (*MON 6*)
Initial screening (*HCLA 1*)
Initial/updated assessment form (*BAL 14*)
Intake evaluation (*COT 7*)
Patient eligibility form (*STL 1*)
Prenatal admission form (*POR 2*)
School/day care (*MON 7*)
Social service intake (*COT 4*)

Policy Research Associates, Inc. • 345 Delaware Avenue, Delmar, New York 12054
Under contract to the Health Resources and Services Administration, Bureau of Primary Health Care

WES 2

MULTNOMAH COUNTY
HEALTH DEPARTMENT

REGISTRATION FORM
ADULT PROBLEM LIST

Allergies	Reactions

DATE ___/___/___

Arrv. Time __ : __ Appt. Time: __ : __ To See ______________________ Client ID: ______________

Last Name ______________________ First: ______________________ Middle: ______________

Date of Birth: __ __:__ __:__ __ __ __ Sex: F M Race: White Black Hispanic Asian/Pacific Native American Other

Interpreter Needed? Yes No

Address: ______________________ Apt. #: ______ City/State: ______________ Zip: ________

Home Phone: (___) ____ - ______ Message/Day Phone: (___) ____ - ______ Message Name: ______________

WIC # ______________ Refugee D.O.E __ __/__ __/__ __ Seas/Migr Worker (circle only if applies): S M

Total Monthly Household Gross Income: $________ Family Size: ______ Disc Level ___ ___

Responsible Party: Last Name ______________________ First: ______________

Billing/Mailing Address: ______________________ City/State: ______________ Zip: ________

Do You Have Insurance Coverage (including Medicaid/Medicare)? Yes No

Social Security Number of Client: __ __ __ - __ __ - __ __ __ __

Problem #	Chronic Problems	Problem Letter	Acute Problems (Self-Limited)
1 (circle one)	Smoker Never smoked Ex-smoker		

(OVER)

MULTNOMAH COUNTY
HEALTH DEPARTMENT

ADULT PROBLEM LIST

Problem #	Chronic Problems	Problem Letter	Acute Problems (Self-Limited)

Names of Household Family Members:	Date of Birth	Relationship

Person to notify in emergency:

Name ______ Address ______ Home Phone ______ Work Phone ______

Support Resources:

Name ______ Agency/Relationship ______ Address ______ Phone Number ______

Name ______ Agency/Relationship ______ Address ______ Phone Number ______

Name ______ Agency/Relationship ______ Address ______ Phone Number ______

Patient Name ______ Birth Date ______

I hereby authorize payment directly to Multnomah County all money to which I am entitled for medical/surgical expenses relative to the services performed.
Date: ____/____/____ Signature of responsible Party ______

(OVER)

2050

POR-400 Rev.7/10/97

TER IR

BOISE CLINIC SOCIAL WORK: BRIEF INTAKE FOR CASE MANAGEMENT SERVICES

Patient name: ______________________ Date: ______________
Address: ______________________ Phone: ______________
Social Security # ______________________

Source of information ______________________
Problem: ______________________

SUBJECTIVE INFORMATION:
1. Medical needs: ______________________

____

2. Background information: ______________________

____

3. Living situation/support: ______________________

____

4. Previous treatment: ______________________

____

5. Financial information: ______________________

OBJECTIVE INFORMATION:
6. Patient's mental health and physical status at this time: ______________________

ASSESSMENT:
7. Needs and services that are required at this time: ______________________

____

____

PLAN:
8. List how patient will receive services:

a. ______________________

b. ______________________

c. ______________________

d. ______________________

ANC 1

CASEMANAGEMENT INTAKE

CASE MANAGER:________________ REFEREED BY:________________________

DATE:____________________________ CHART#:______________________________

NAME:___________________________ DOB:_________________________________

CONTACT PHONE #:______________ CURRENT MEDICATION:_________________

SUBJECTIVE

HOUSING (Where/ address):____________________________________How long?___________
PREVIOUS:____How long?___________
TRANSPORTATION:_______________________INCOME:_________________________________
EMPLOYMENT:__________________________EDUCATION (skills):_______________________
MEDICAL ISSUES:____
____
MENTAL HEALTH:____
SUBSTANCE ABUSE:____
TREATMENT PROGRAM ER:____
FAMILY(SUPPORT SYSTEMS):____
OTHER:____

SERVICES APPLIED FOR OR CURRENTLY RECEIVING:

OBJECTIVE:

APPEARANCE: Clean Appropriate dress for weather and circumstances?:_______________
Disheveled Poor hygiene Casual dress Well dress_______________________

- **Signs or symptoms of chemical dependency?** Yes ____________________ No __________
- **Eye contact** *(circle one)*: GOOD / FAIR / POOR
- **Noticeable odors?** Yes ____________________ No ________________________

AFFECT *(circle one)*: APPROPRIATE ↔ INAPPROPRIATE ↔ HAPPY ↔ SAD ↔ FLAT ↔ LABILE↔ RESERVED↔SOCIABLE ↔ COOPERATIVE ↔ NEGATIVISTIC

MOOD *(Circle one)*: NORMAL / DEPRESSED / IRRITABLE / APATHETIC / ANXIOUS / AGITATED / EXPANSIVE / MANIC.

ASSESSMENT:

PLAN:

RESOURCES / REFERRALS:

1. Div. and Public Assistance ____________________
2. Social Security ____________________
3. Veterans Administration ____________________
4. Housing ____________________
5. Employment ____________________
6. Mental Health ____________________
7. Medical ____________________
8. Dental ____________________
9. Vision ____________________
10. Social Services ____________________
11. Substance abuse TX ____________________
12. Food ____________________
13. Clothing ____________________
14. Transportation ____________________
15. Counseling ____________________
16. Supportive Counseling given? __________

    RE: ____________________
17. Community Resource list given.
18. Business cards given for follow up.
19. How long in Homeless Program? ______

    ____
20. Other? ____________________

COMMENTS:

BIR 4

ACCOUNT NO. ____________ (ENTRY.FRM - 5/3/96) CHART NO. ____________

****

BIRMINGHAM HEALTH CARE - CLIENT INTAKE FORM

DATE ____________ SOCIAL SECURITY NUMBER ______-______-______

PRINT CLIENT FIRST NAME ____________ PRINT CLIENT MIDDLE NAME ____________ PRINT CLIENT LAST NAME ____________

ADDRESS (OR SHELTER) ____________

CITY ____________ STATE ______ ZIP CODE ______ HOME PHONE ____________

WHO REFERRED YOU TO BIRMINGHAM HEALTH CARE? ____________

HAVE YOU PREVIOUSLY BEEN SEEN BY BIRMINGHAM HEALTH CARE? YES_____ NO_____; IF SO, WHEN? ____________

CIRCLE ONE OF THE FOLLOWING: EMPLOYED FULL-TIME, EMPLOYED PART-TIME, RETIRED, DISABLED, STUDENT, UNEMPLOYED, OTHER

PLACE OF EMPLOYMENT ____________ WORK PHONE ____________ EXT. ______

BIRTH DATE ___-___-___ SEX: M F RACE ____________ AGE ______

CIRCLE ALL THAT APPLY: SINGLE, MARRIED, SEPARATED, DIVORCED, WIDOW, PART-TIME STUDENT, FULL-TIME STUDENT

IF APPLICANT IS UNDER 18 YEARS OF AGE CIRCLE ONE OF THE FOLLOWING:
LIVES WITH BOTH PARENTS, MOTHER, FATHER, RUNAWAY, OTHER RELATIVE, OTHER

FAMILY SIZE: NUMBER OF FAMILY MEMBERS IN HOUSEHOLD ____________

HIGHEST EDUCATION LEVEL ATTAINED (CIRCLE ONE):
PRE-SCHOOL GRADE SCHOOL SOME HIGH SCHOOL HIGH SCHOOL GRADUATE GED
SOME COLLEGE COLLEGE GRADUATE VOCATIONAL/TECHNICAL SCHOOL NONE UNKNOWN

ANNUAL INCOME OF CLIENT ____________ ANNUAL INCOME OF FAMILY ____________
SOURCE OF INCOME ____________

CIRCLE ONE OF THE FOLLOWING: VIETNAM VETERAN OTHER VETERAN NON-VETERAN

HOUSING STATUS - CLIENT LIVES (CIRCLE ONE):
STREET, SHELTER, DOMESTIC VIOLENCE SHELTER, SUBSTANCE ABUSE FACILITY, TRANSITIONAL HOUSING, RENTAL HOUSING,
OWNS HOME, LIVING WITH RELATIVES, LIVING WITH OTHERS, OTHER (EXPLAIN) ____________

CIRCLE ALL BENEFITS YOU ARE CURRENTLY RECEIVING:
SOCIAL SECURITY, SOCIAL SECURITY SUPPLEMENTAL INCOME (SSI), SOCIAL SECURITY DISABILITY INCOME (SSDI), VA, FOOD STAMPS,
AFDC, WIC, OTHER (LIST) ____________

****

EMERGENCY CONTACT:

NAME ____________ HOME PHONE ____________ WORK PHONE ____________

STREET ADDRESS ____________ CITY ____________ STATE ______ ZIP ______

****

DO YOU HAVE MEDICAID? YES NO DO YOU HAVE MEDICARE? YES NO DO YOU HAVE OTHER INSURANCE? YES NO

CARRIER ____________ CODE ______

GROUP NUMBER ____________ POLICY NUMBER ____________ COVERAGE FROM ______ TO ______

CARRIER STREET ADDRESS ____________

CITY ____________ STATE ______ ZIP ______ PHONE ____________

****

HAS ANY OF THE ABOVE INFORMATION CHANGED SINCE YOUR LAST VISIT? YES______ NO______
IF YES, PLEASE IDENTIFY THE CHANGE(S) ____________

WHAT TYPE OF SERVICE(S) ARE YOU REQUESTING TODAY?

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I ALSO AGREE TO HAVE ANY INSURANCE PAYMENTS ASSIGNED TO BIRMINGHAM HEALTH CARE FOR THE HOMELESS COALITION, INC.

CLIENT SIGNATURE ____________ DATE ____________
(CLIENT, PARENT, OR LEGAL GUARDIAN)

COM-1

HOMELESS PROGRAM INTAKE

HOMELESS INTAKE #: ______ DATE: ______ Date off Program CHART #: ______

ABOVE COMPLETED BY CHC STAFF ONLY

PATIENT NAME: ______________________ Homeless Program Status: New Update Reentry

EDUCATION LEVEL: 0-8 9-12 Non-grad HS Grad/GED 12+ College Grad

MARITAL STATUS: Single Married Widowed Separated Divorced

Temp Address: ______________________________________ Phone: ____________

CURRENT LIVING CONDITION (Circle one): Shelter, Transitional Housing, Living On Street, Abandoned Building/House, Tent, Car/Vehicle, Halfway House, Doubled up with family/friend.

Prior Residence: ______________________________________

REASONS FOR HOMELESSNESS:

___ Domestic Violence
___ Loss of Job
___ Loss of Public Assistance
___ Release from Mental Health
___ Release from Jail/Prison
___ Other family dispute
___ Natural Disaster/Family
___ In Transit/Relocating
___ Evicted by Relatives/Friends
___ Evicted by Landlord
___ Insufficient Income
___ Alcohol Abuse
___ Substance Abuse
___ Runaway
___ Overcrowding

PLEASE LIST ALL FAMILY MEMBERS LIVING WITH YOU

NAME	LAST, FIRST	DOB	SEX	RACE	SS#	CHART#
HEAD OF HOUSE						
SPOUSE						
CHILD						
CHILD						
CHILD						
CHILD						
CHILD						

PERSON TO CONTACT IN AN EMERGENCY: (NOT LIVING AT YOUR RESIDENCE)
NAME: ____________________ PHONE: ____________ RELATIONSHIP: ____________

DO YOU HAVE INSURANCE COVERAGE? ___ YES ___ NO V.A. Medical Benefits ___ YES ___ NO
INSURANCE COMPANY: ____________________ POLICY #: ____________

MEDICARE #: ____________ PART A: ________ PART B: ________ SSI: ________

MEDICAID #: ____________ STATE: ________
IF IOWA MEDICAID SPECIFY TYPE TITLE 19 ________ HMO: ________ MEDIPASS: ________

BENEFITS (Check or specify monthly amount currently receiving)

$________ a. AFDC/Public Aid
$________ b. Food Stamps
$________ c. SS/SSI/SSD
$________ d. VA Pension/Disability
$________ e. Employment Wages/Pension
$________ f. Unemployment Insurance
$________ g. WIC
$________ h. General Assistance

HISTORY AND PHYSICAL

NAME ______ Date ______
DOB ______
Chart # ______

DRUG ALLERGIES

______
______
______
______

CURRENT MEDS

______
______
______
______

FAMILY HISTORY

	Dad	Mom	Dads Par	Moms Par	Sibs	Kids
Heart Disease	__	__	__	__	__	__
High Blood Pressure	__	__	__	__	__	__
Stroke	__	__	__	__	__	__
Cancer	__	__	__	__	__	__
Glaucoma	__	__	__	__	__	__
Diabetes	__	__	__	__	__	__
Epilepsy/Convulsions	__	__	__	__	__	__
Bleeding Disorder	__	__	__	__	__	__
Kidney Disease	__	__	__	__	__	__
Thyroid Disease	__	__	__	__	__	__
Mental Illness	__	__	__	__	__	__
Osteoporosis	__	__	__	__	__	__
Emphysema/Asthma	__	__	__	__	__	__
Alcohol/Subst Abuse	__	__	__	__	__	__

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

WOMEN: Pregnant? ____ Yes ____ No Planning pregnancy? ____ Yes ____ No
Pregnancies ____ Live Births ____ Miscarriages ____ Abortions ____
Stillbirths ____ Type of birth control ____ LMP ____
Date of last pap ____ Abnm pap ____ Yes ____ No ____ Tx ____

MEN: Date of last physical ____

PAST MEDICAL HISTORY

__ Headache
__ Shortness of breath
__ Heart Palpitations
__ Heart Murmur
__ Chest Pain
__ Dizziness/Fainting
__ Vascular disease
__ Allergies/Hay Fever
__ Asthma
__ Bronchitis
__ Pneumonia
__ Ulcer
__ GI Disorder
__ Lactose Intolerance
__ Gall Bladder Disease

__ Prostate Disease
__ Bowel Irregularity
__ Incontinence
__ Sexual/Menstrual dysfunction
__ Epilepsy/Convulsions
__ Frequent infections
__ Hepatitis
__ Anemia
__ Arthritis
__ Osteoporosis
__ Nervousness
__ Depression
__ Gout
__ Scarlet Fever
__ Chronic rashes

		WHEN
__	Rheumatic Fever	____
__	Mumps	____
__	Measles	____
__	Rubella	____
__	Polio	____
__	Diphtheria	____
__	Tetanus	____
__	Gonorrhea	____
__	Trichomonas	____
__	Syphilis	____
__	Veneral Warts	____
__	Genital Herpes	____
__	HIV +	____
__	Chlamydia	____

FAM 1

Family Health Foundation, Inc.
Healthcare for the Homeless Project
111 N. Market St., Suite #402
San Jose, CA 95113
(408) 279-6244

INTAKE FORM

Date: ____________________ Service Site: ____________________

Name: ______________________________ Ethnicity: ____________
DOB: ______________ Age: ________ SS#: ____________________

Spouse: ______________________________ Ethnicity: ____________
DOB: ______________ Age: ________ SS#: ____________________

Address: ____________________________ Phone #: ______________
City: ______________ Zip: ________ Pager #: ______________

Family Size: ______ Child(ren) Boys: __________ Girls: __________
(Ages of Children)

Source of Income: ________________ $ __________ $ __________

What type of insurance do you have? Blue Cross, Santa Clara Family Health Plan, MediCal, Medicare, VA, Other: ____________________
Immediate Medical Need: ____
____

Are you on the streets, living in your car, staying with friends/relatives, living in a shelter? ______________________________________
Have you received the Homeless Assistance from the Department of Social Services? ____________________ When? ____________________
Immediate Housing Need: ____
____
____

Referred by: ____________________________ Agency: ______________

Call-in Client _____ Walk-In _____

Action/Comments: ____
____
____
____
____

HCLA 5

HOMELESS HEALTH CARE LOS ANGELES
INTAKE FORM

STAFF: ______________________

HHCLA: 1992, REVISED: 10/01

PERSONAL INFORMATION

Name: ______________________ D.O.B.__________

Phone # where you can be reached: ______________

Mailing address: ______________________

____

Birthplace: ______________________

Date arrived in L.A. County: ______________

REFERRAL INFORMATION

Referred by:

____
Agency Contact Phone #

Are you working with any other agencies? Yes ☐ No ☐

____
Agency Contact Phone #

____
Agency Contact Phone #

Are you on probation/parole? Yes ☐ No ☐

Office: ______________________

Address: ______________________

____

Contact: ______________ Phone: __________

RESOURCES

Circle Type of Identification: Drivers License, CA ID Card, Medi-Cal Card, Birth Certificate, Other

Is client receiving public assistance? Yes ☐ No ☐

Specify Type: ______________________

Date last rec'd: ______________ Amount: __________

DPSS, Vet., SSI Office: ______________________

Address: ______________________

INTAKE DATE: ______________________

Are you experiencing any problems with your benefits?

Indicate: ______________________

____

____

____

FAMILY INFORMATION

Spouse/Partner: ______________________

Sex: ☐ Male ☐ Female

Child's Name	D.O.B.	Sex	w/Mom/Dad/Other?

Do you have an open DCFS case? Yes ☐ No ☐

Office: ______________________

Address: ______________________

Worker: ______________ Phone # __________

Do you have childcare arrangements? Yes ☐ No ☐

Do you plan to participate in childcare? Yes ☐ No ☐

EMERGENCY CONTACT

Name:

____

Address:

____

____

Phone # ______________ Relationship: __________

LOS 2

HOMELESS HEALTH CARE LOS ANGELES
INTAKE FORM

Intake Counselor: ______________________

Intake Date: ______________________ 19____

PERSONAL INFORMATION

Name: ______________________ D.O.B. ________

Phone # where you can be reached: ______________________

Mailing address: ______________________

____

Date arrived in L.A. County: ______________________

Education: Highest grade completed ______________________

Are you currently employed? Yes ____ No ____

Employer: ______________________ Phone: ________

Have you ever been in job or vocational training?
Yes ____ No ____ (specify: when, where, type)

____

____

FAMILY INFORMATION

Spouse/Partner: ______________________

Sex: Male ______ Female ______ Birthplace: ______________________

DOB: ______________________ Age: ________

Social Security #: ______________________

Child's Name	DOB	Sex	with mother/ father/other?	Immunizations? yes/no

Do you have child care arrangements? Yes ____ No ____

Provider: ______________________ Phone: ________

Circle Type of ID: Drivers License, I.D. Card, Medi-Cal, Birth Certificate.

Other: ______________________

REFERRAL INFORMATION

Referred by:

Agency	Contact	Phone

Are there other agencies now working with you?
Yes ____ No ____

Agency	Contact	Phone

Are you on probation/parole? Yes ____ No ____

Office: ______________________

Address: ______________________

Contact: ______________________ Phone: ________

Do you have an open DCS case? Yes ____ No ____

Office: ______________________

Address: ______________________

Contact: ______________________ Phone: ________

RESOURCES

	Is client receiving?	Date applied?	Date last rec and amount
Homeless Family Grant (AB1733)			
A.F.D.C.			
Food Stamps			
Medi-Cal			
WIC			
General Relief			
Social Security			
Veteran Benefit			
Child Support			
Work			
Other			

DPSS, Vet., SSI Office: ______________________

Eligibility Worker: ______________________

Phone hrs. ______________________ Case #: ________

Is client having any problems with benefits? ______________________

____

EMERGENCY CONTACT

Name: ______________________

Address: ______________________

____

Phone: ______________________ Relationship: ________

LOS 2R

HOMELESS HEALTH CARE LOS ANGELES
INTAKE FORM

Intake Counselor: ______________________

Intake Date: ______________________

PERSONAL INFORMATION

Name: ______________________ D.O.B. ________

Phone # where you can be reached: ______________

Mailing address: ______________________

____

Birthplace: ______________________

Date arrived in L.A. County: ______________

REFERRAL INFORMATION

Referred by:

____
Agency Contact Phone #

Are you working with any other agencies? Yes ____ No ____

____
Agency Contact Phone #

____
Agency Contact Phone #

Are you on probation/parole? Yes ____ No ____

Office: ______________________

Address: ______________________

Contact: ______________ Phone: ________

RESOURCES

Circle Type of Identification: Drivers License, CA I.D. Card, Medi-Cal Card, Birth Certificate, Other ______________

Is client receiving public assistance? Yes ____ No ____

Specify: ______________________

Date last rec'd: ______________ Amount: ________

DPSS, Vet., SSI Office: ______________

Address: ______________________

____

Worker: ______________ Case #: ________

Phone # ______________ Phone hrs. ________

Are you experiencing any problems with your benefits?

Indicate: ______________________

____

____

____

FAMILY INFORMATION

Spouse/Partner: ______________________

Sex: Male ________ Female ________

Child's Name	D.O.B.	Sex	with mother/ father/other?

Do you have an open DCFS case? Yes ____ No ____

Office: ______________________

Address: ______________________

Worker: ______________ Phone # ________

Do you have child care arrangements? Yes ____ No ____

Do you plan to participate in the CEP? Yes ____ No ____

EMERGENCY CONTACT

Name: ______________________

Address: ______________________

____

Phone # ______________ Relationship: ________

TER 1

TERRY REILLY HEALTH SERVICES

Boise Clinic

HEALTH CARE FOR THE HOMELESS

Intake Form

Date: ______ Client Name: Last ______ First ______

Address: ______ Telephone: ______ SSN: ______

Gender: M☐ F☐ *VETERAN: Y☐ N☐ Birth Date: ______

***FINANCIAL RESOURCES: Check all appropriate.**

1) AFDC ☐
2) SSI/D ☐
3) WIC ☐
4) Food Stamps ☐
5) Other VA Benefits ☐
6) Unemployment Insurance ☐
7) Wages and Pension ☐
8) Other: ______ ☐
9) None ☐

***MEDICAL RESOURCES: Check all appropriate.**

1) Medicaid ☐
2) Medicare ☐
3) Insurance ☐
4) Self-Pay ☐
5) VA Medical ☐
6) County ☐
7) Other: ______ ☐
8) None ☐

***SOCIAL UNIT**

1) Unattached Adult ☐
2) Unattached Youth (Age 19 and under) ☐
3) Adult in Family ☐
4) Child in Family ☐
5) Under Age 19 Head of Household ☐
6) Unknown/Unreported ☐

EDUCATION

1) Grade School ☐
2) Some High School ☐
3) High School Graduate ☐
4) College ☐
5) Trade School ☐
6) Other ______ ☐

RACE

1) White ☐
2) Black ☐
3) Native American ☐
4) Hispanic ☐
5) Asian/Pacific Islands ☐
6) Other ______ ☐

REFERRED FROM

1) Treatment ☐
2) Hospital/E.R. ☐
3) Shelter ☐
4) Ada County ☐
5) Community House ☐
6) Other ______ ☐

BEEN HOMELESS SINCE: ______ (Continuous ______ Off/On) ______

BEEN IN BOISE AREA SINCE: ______ ARRIVED FROM: ______

REASON FOR COMING TO BOISE: Work______ Family (Problem/Help)______ Other ______

CURRENTLY EMPLOYED: Y☐ N☐ CURRENT MONTHLY INCOME: (If Any) ______

LAST FULL TIME JOB: (Date) ______ LEFT JOB BECAUSE: ______

JOB REQUIRED: Skilled ______ Unskilled ______ Labor ______

***CURRENT LIVING ARRANGEMENT**

1) Shelter ☐
2) Transitional ☐
3) Friends/Relatives (Doubling Up) ☐
4) Street ☐
5) Treatment ☐
6) Other: ______ ☐
7) Unknown/Unreported ☐

***FAMILY RELATIONS**

Closeness to Mother: Y☐ N☐
Closeness to Father: Y☐ N☐
Size of Family of Origin:
Large: (3 or more children) ☐
Small: (1-2 children) ☐

STATUS SUMMARY

Homeless Y☐ N☐
Date ______

Homeless Y☐ N☐
Date ______

Homeless Y☐ N☐
Date ______

Homeless Y☐ N☐
Date ______

In the past year, have you experienced and/or been treated for:

Substance Abuse? Y☐ N☐
ETOH Abuse? Y☐ N☐
Mental illness/mental health problems? Y☐ N☐

If so: when, where and by whom?

______

______

Provider Signature: ______ Date: ______

SEA 1

HEALTH CARE FOR THE HOMELESS

INTAKE/ENCOUNTER FORM

Client New to Provider ☐ No ☐ Yes

(Birthdate) MO DAY YEAR

Client ID

Client Name, Last

First ____ MI ____

Clinic Field (optional)

COMPLETE IF PATIENT IS NEW TO HCH OR WITH A CHANGE

Gender: ☐ M ☐ F
Veteran: ☐ Y ☐ N
☐ Served in Vietnam
☐ Interpreter Used
☐ Interpreter Needed

EDUCATION
☐ Grade School
☐ Some High School
☐ HS Grad/GED
☐ Voc/Tech
☐ Some College
☐ College Graduate

SOCIAL UNIT
☐ Single Adult
☐ Minor Living Alone
☐ Family
____ Adults
____ Children

RACE
☐ White
☐ Black
☐ Asian/Pacific Islander
☐ Hispanic
☐ Amer. Ind./AK Native
Tribe ____
☐ Multi-Racial
☐ Other ____

BENEFIT STATUS (R - RECEIVING, A = APPLIED, U = UNK)
____ Medicare
____ Medicaid
____ Managed Care
____ Plan
____ Exempt
____ VA
____ SSI
____ Private Insurance
____ Food Stamps
____ Social Security
____ WIC
____ GAU
____ AFDC/GAS
____ ADATSA
____ Other ____
____ None

COMPLETE BELOW FOR EACH VISIT

VISIT DATE

SITE OF SERVICE

LEAD HEALTH CLINIC

STATUS
☐ Street
☐ Shelter
☐ Hospital
☐ Jail
☐ At Risk
☐ Friends/Relatives
☐ Treatment Facility
☐ Transitional Housing
☐ Other ____

SERVICE TYPE
☐ Direct
☐ Administrative
☐ Collateral Contact
☐ Died

HEALTH PROBLEMS*
___ Alcohol Dependence
___ Anemia
___ Cardiovascular
___ COPD
___ Diabetes
___ Dental
___ Developmental Disorder
___ Domestic Abuse
___ Drug Dependence
___ GI Disorder
___ Hypertension
___ Mental Disorder
___ Nutritional Disorder
___ Situational/Interpersonal
___ PVD
___ Skin Disorder
___ STD
___ Trauma
Tuberculosis
___ Previous
___ Infected
___ Active
___ Other

PREGNANT
___ Yes
___ No
___ DK

PRENATAL CARE
___ Yes
___ No

IMMUNIZATIONS
___ Up-to-Date
___ Scheduled/Referred
___ Completed This Visit
___ Refused

SERVICES PROVIDED
___ Assessment/Screening
___ Counseling/Teaching
___ Crisis Intervention
___ Nursing Care
___ Primary Medical Care
___ Social Services/Support
___ Dental
___ Respite
___ Well Child Exam
___ HIV Prevention Counseling
___ HIV Prevention Packet
___ Spiritual Counseling

*If HIV+ or AIDS/ARC, fill out an HIV Log form

Provider Signature ____ ☐ MD ☐ NP/PA ☐ RN ☐ MH ☐ SW/CM ☐ CDC ☐ DENTAL

Provider Code (Optional) ____

Revised 1/94
HCHINTKE.PM4

MON 6

New York Children's Health Project
Division of Community Pediatrics

Name: *Last* *First*

MR #: 0 0 1 – ___ ___ – ___ ___ – ___ ___

INITIAL DEMOGRAPHIC

DATA ENTRY USE ONLY
Current Housing Status: (1)

Angel –	HO	Icahn –	SH	Saratoga –	SH
Convnt –	SH	Kenned –	HO	StJohns –	SH
FlatId –	SH	Powers –	AC	Skyway –	HO
HealthySt –	ZZ	ProsInn –	SH	StWork –	RU
				Other –	___

HOW LONG HAS YOUR FAMILY BEEN IN THE SHELTER SYSTEM, THIS TIME? (2)

___ Weeks *(If Less Than One Month)*

___ Months ___ Years

HAVE YOU EVER BEEN IN THE SHELTER SYSTEM BEFORE? (6)

- ☐ Yes – How Many Times? ___
- ☐ No

HOW MANY DIFFERENT SITES HAVE YOU STAYED IN SINCE ENTERING THE SHELTER SYSTEM, THIS TIME?

___ (3)

WHO LIVES WITH YOU IN THE SHELTER? *(Include Respondent)*

___ Adults (4)

___ Children (5)

WHERE WAS YOUR FAMILY LIVING BEFORE ENTERING THE SHELTER SYSTEM, THIS TIME? (7)

- ☐ Own Apartment (Leased) (oa)
- ☐ With Family (fa)
- ☐ With Friends (fr)
- ☐ Other: (ot) ___
- ☐ Rented Room (rr)
- ☐ Multiple Locations (ml)
  Specify: ___ *(Last 3 Mos.)*

WHAT WAS THE MAIN REASON THAT YOU ENTERED THE SHELTER SYSTEM? (8)

- ☐ Too Crowded (cr)
- ☐ Too Crowded - "Doubled Up" (du)
- ☐ Family Problems (fp)
- ☐ Domestic Violence (dv)
- ☐ Substance Abuse (su)
  - ☐ Mother (sm) ☐ Father (sf) ☐ Both (sb)
- ☐ Moved From Another City (mc)
- ☐ Poor Conditions In Apartment / Building (pc)
- ☐ Drugs / Violence In Neighborhood (nh)
- ☐ Fire (fi)
- ☐ Evicted By Landlord (ev)
- ☐ Couldn't Pay Rent (cp)
- ☐ Conflict With Landlord (cl)
- ☐ Other: (ot) ___

Comment: ___

S & S, INC. 72418 (5/95)

HCLA - 1

INITIAL SCREENING

Name: ______________________ Client's Date of Entry: ____________ Readmit: Y or N Year ______

Address: ______________________________________ Phone: ______________________

D.O.B. ______ Age ______ Race ______ I.V. Drug User: Y or N Family: Y or N Is client pregnant? Y or N

Referred by:
GR or Cal-Works Mandated? If Yes _____ CASC'S Name: __________ If No, by Whom: Probation: _____ Parole: ______

DCFS: __________ Courts: __________ Walk-in: ____________ Other: __________

Present Drug and Alcohol use:
DRUG (S) USAGE AND LAST USE: Cocaine/Crack: _____ Alcohol: _____ Heroin: _____ Marijuana: _____ Other: ______

How many years using: ______ In the last 30 days how many days has the client used? ________ Money Spent ______

Comment: ____

Treatment History:
How many TX Programs has the client been in? ________ How many completed? __________

Name and date of most recent program: ______________________________

Comment: ____

____

Living Situation:
Is Client Homeless or Near Homeless: Y ___ N ____ the client is staying: ______________________

Has been there since? ______________ Expected length of stay? ______________________

Comment: ____

____

Current Mental Health Issues:
Has the client ever been diagnosed with a Mental Disorder? Y or N DX=______________________
Is the client currently seeing a psychiatrist for any reason? Y or N Where:______________________
Is client taking any psychiatric medication? Y or N Type of Meds.______________________
Has the client attempted Suicide? Y or N How Many Times:______________________

Explain: ____

____

Recommendations:
Eligible: __________ Appt's Schedule with: ____________ Date: __________ Time: ______ For: ______

Comments: ____

____

____
Staff Signature

BAL 14

HCH, INC. / CONNECT PROJECT

INITIAL/UPDATED ASSESSMENT FORM

Date: ______________ Case Manager: ______________________

Current Client Residence: ______________________________

____

How Long? ______________

Mailing Address: ______________________________

____

Telephone No.: ______________

Soc. Sec. No: ______________

Date of Birth: ______________

BENEFITS		
Current	Applied (Date)	Pending
☐ MC		
☐ FS		
☐ TEMHA		
☐ BUS PASS		
☐ PA/TAP		
☐ MA		
☐ SSI/SSDI		
OTHER: ______		

Referral Source: ______________________________

Referral Address: ______________________ Phone/Fax: ______________

Reason for Referral: ______________________________

Patient Aware of Referral? ☐ Yes ☐ No

Tier I ______________

Program Eligibility: ☐ HIV+ ☐ S.A. ☐ M.H.

Tier II ______________

CD4 ______________ VL ______________

Additional Illness: ______________________ Referred: ______________

Medications: ______________________________

Current Needs:
- ☐ Housing
- ☐ Mental Health
- ☐ Income
- ☐ Health Insurance
- ☐ Medical Care
- ☐ Addictions
- ☐ Employment
- ☐ Job Training/Education
- ☐ Transportation
- ☐ Food
- ☐ Support Group/Buddy
- ☐ Other ______________

Social Support (Family History): ______________________________

____

____

____

Housing Status: ______________________________

Education: ______________________________

Employment History: ______________________________

Are they receiving:	No	Yes	Contact	Provider	Phone #
-Medical Care?					
-Mental Health Services?					
-Addiction Treatment?					

CLIENT LAST NAME: ______________ FIRST: ______________ HCH#: ______________

History of Substance Abuse? ☐ No ☐ Yes

Drug of Choice: ______________________ ☐ N/A

Treatment History ______________________

Presenting Medical Problems: ______________________

Psycho-Social Problems: ______________________

Medications: ______________________

Legal/Criminal History: ______________________

Religious Affiliation/Spiritual Beliefs: ______________________

Contact Person (Next of Kin:) ______________________ Phone: __________

INITIAL/UPDATED CARE PLAN

GOALS	OBJECTIVES	OUTCOME

____
Client's Signature

____
Signature of Case Manager

Provider Code

Date of Plan

COT 7-1

Charter Oak Terrace-
Rice Heights
Health Center, Inc.

81 Overlook Terrace, Hartford, CT 06106 • (203) 226-0857

Clinical Family Services
Intake Evaluation

Patient: ____________________

Date of Birth: ____________________

Date of Evaluation: ____________________

Provider: ____________________

Identifying Information: (include demographics, family, referral source, etc.)

Presenting Problem and History: ____________________

Name ____________________ Chart# ____________________

COT 7-2

Past Psychiatric History: ____________________

____

____

____

Substance Abuse History: ____________________

____

____

____

Family History: (include significant psychiatric, medical, environmental, legal problems, etc.)

____

____

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Name: ____________________ Chart#: ____________

COT 7-3

Other Significant History: (developmental, medical, employment, educational, social, etc.) ______

______

______

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______

Mental Status Examination/Clinical Impressions: ______

______

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______

Name: ______ Chart#: ______

COT. 7-4

Mental Status cont...

<u>DSM III-R Diagnoses</u>:

Axis I:

Axis II:

Axis III:

Axis IV: Psychosocial Stressors:

Severity:

Axis V: Current GAF: GAF Past Year

<u>Disposition</u>:

Name: Chart#:

COT 7-5

Treatment Plan:

Problems: ______________________________

Goals: ______________________________

Objectives: ______________________________

Clinician: ______________________________

Supervisor: ______________________________

Name: ______________________________ Chart#: ______________________________

9/92 dmb/vg

STL 1

COU	☐	ST. LOUIS COUNTY
FCC	☐	FAMILY CARE CENTER
PHC	☐	PEOPLES HEALTH CENTER
SLC	☐	ST. LOUIS COMPREHENSIVE
RMC	☐	ST. LOUIS REGIONAL MEDICAL CENTER
SAL	☐	SALVATION ARMY

HCC ☐ HEALTH CARE FOR THE HOMELESS (HCHC)

Service Site ______

Adult ______ Child ______ Accompanying Parent:

H.C.H. PATIENT ELIGIBILITY FORM

1 DATE OF SERVICE: ______ 2 NEW PATIENT: **Y** or **N** 3 VETERAN: **Y** or **N**

4 NAME: ______ (LAST) ______ (FIRST) ______ (MI)

5 SOCIAL SECURITY # ______ ______ ______ 6 BIRTHDATE: ____/____/____ 7 SEX: **M** or **F**

8 HEAD OF HOUSE: **Y** or **N** FAMILY SIZE ______ 9 INCOME $ ______ 10 MARITAL STATUS: **S M W D X SEP**

11 ETHNIC GROUP: 1 =Black 2 =White 3 =Other 4 =Hispanic 5 =Native American 6 =Pacific Islander

12 CHECK CURRENT RESIDENCE BELOW: 13 RUNAWAY (under 20) **Y** or **N**

- ____ SHELTER .... NAME OF SHELTER: ______
- ____ INSTITUTION .... NAME OF INSTITUTION: ______
- ____ FRIENDS/RELATIVES .... DATE FORCED TO LEAVE REGULAR RESIDENCE? ______
- ____ PERSONAL RESIDENCE .. ADDRESS: ______
- ____ NONE ______

14 DATE PLACED IN PERMANENT HOUSING? ______ PHONE ______ ______

15 a.) SOURCE OF INCOME:

___ AFDC	___ MEDICAID	___ MEDICARE	___ SSI	___ FOOD STAMPS
___ PENSION	___ GENERAL RELIEF	___ WIC	___ UNEMPL	___ PRIV. INS.
___ VA BENEFITS	___ JOB FULL TIME	___ JOB PART TIME	___ OTHER	

b). ELIGIBLE FOR STATE ENTITLEMENTS? **Y** or **N** c). APPLIED FOR? **Y** or **N**

16 DIAGNOSES

INFECTIOUS DISEASES
- PRTBI ☐ Prior TB Infection
- 795 ☐ New TB Infection
- 0119 ☐ Active TB Disease
- 0999 ☐ STDs
- 0709 ☐ Hepatitis B
- V640 ☐ Incomp. Immunizations
- 1369 ☐ Other Reportable Dis.

MENTAL ILLNESS/DISORDERS
- 3009.3 ☐ Severe Mental Ill.
- 7834 ☐ Developmental Delays
- 319 ☐ Mental Retardation

SOCIAL CONDITIONS
- 3039 ☐ Alcohol Dependence
- 3059 ☐ Drug Dependence
- 9599.5 ☐ Trauma
- 9955 ☐ Child Abuse
- 9955.3 ☐ Adult Abuse

ENDOCRINE/NUTRITIONAL/DIGESTIVE
- 2500 ☐ Diabetes Mellitus
- 2639 ☐ Nutritional Disorders
- 2809 ☐ Anemia
- Y53 ☐ Dental/Oral Disease
- 5589.2 ☐ GI Disorders

SELF-LIMITED AND OTHER COND.
- 7099.1 ☐ Skin Diseases
- 991 ☐ Exposure cold/heat
- V222 ☐ Pregnancy
- 1369 ☐ Acute Infections
- V49 ☐ Ill Defined Conditions

RESPIRATORY/CIRCULATOF
- 4010 ☐ Hypertension
- 4439.2 ☐ Peripheral Vascular D
- 486 ☐ Pneumonia
- 4871.2 ☐ Influenza
- 519 ☐ Chronic Resp. Cond.
- OTHER ☐ Other
- ______ ☐ ______
- ______ ☐ ______

17 Is service being performed by a Community Health Nurse or MSW? **Y** or **N** Circle those that apply:

a.) Assistance with Entitlement Programs b.) Assessment c.) Follow-up d.) Referral and Linkage

e.) Out Reach f.) Triage g.) Transportation h.) Other

18 Is service being performed by? Circle one:

KEY	PROVIDER TYPE	KEY	PROVIDER TYPE	KEY	PROVIDER TYPE
MD	PRIMARY CARE PHYSICIAN	RN	NURSES - MEDICAL	CM	CASE MANAGEMENT
MH	MENTAL HEALTH/PSYCHIATRY	DN	DENTIST	SA	SUBSTANCE ABUSE
OM	OTHER MEDICAL/SURG. SPEC.	DH	DENTAL HYGIENTIST		
MP	MIDLEVEL PRACTITIONER	OH	OTHER HEALTH/CHIROPRACTOR		

POR 2

PRENATAL ADMISSION FORM

Client Name:______________ DOB:________ Age:________ Referred by:____________

Address:______________ Telephone #:____________ Agency:____________

Medicaid #:________ EDD:______ G:___ P:_____ Planned Pregnancy: Yes No Telephone:____________

Care Provider:______________ Onset of Care:____________ Call Taken by:____________

# of Children at Home:________ Ages:______________ Date Taken:____________

Problems with Pregnancy/Recommendations: Quarter: 1 2 3 4

CT#:______ PHN:________

Social History/Recommendations for PHN:

Phone Consultation:________ Refused Services:________ Unable to Locate:________

	(Circle One)				(Circle One)				(Circle One)		
Onset of Prenatal Care: 1st	2nd	3rd	None	**Domestic Violence:**	Yes	No	U	**Cognitive Limitations:**	Yes	No	U
Complications of Pregnancy:	Yes	No	U	**Current CPS Involvement:**	Yes	No	U	**Active Tobacco Use:**	Yes	No	U
Other Children in Care:	Yes	No	U	**History of CPS Involvement:**	Yes	No	U	**Passive Tobacco Exp.:**	Yes	No	U
English is not 1st Language:	Yes	No	U	**Physical Disability:**	Yes	No	U	**Alcohol Use:**	Yes	No	U
Homeless in Last Year:	Yes	No	U	**Chronic Physical Illness:**	Yes	No	U	**Other Illegal Sub.:**	Yes	No	U
Substandard Housing:	Yes	No	U	**History of STDs:**	Yes	No	U	**IVDU:**	Yes	No	U
Trouble with the Law:	Yes	No	U	**Mental Illness:**	Yes	No	U	**Self Referral:**	Yes	No	U

Rev. 9/96

POR 2

MONTEFIORE

New York Children's Health Project
Division of Community Pediatrics

Name: *Last* _______ *First* _______

MR #: 0 0 1 – ___ ___ – ___ ___ – ___ ___

SCHOOL / DAY CARE

HOW MANY YEARS OF SCHOOL WERE YOU (MOTHER) ABLE TO COMPLETE?

- ________ # of Years (1 to 11)
- ☐ H.S. Graduate (hs)
- ☐ G.E.D. (ed)
- ☐ Voc. Training (vt)
- ☐ Mother Not Primary Caregiver
- ☐ Some College (sc)
- ☐ College Grad (cg)
- ☐ Unknown (un)
- ☐ Other (ot)

Specify: ________________

IF THE CHILD IS LESS THAN 5 YEARS OLD, IS YOUR CHILD ENROLLED IN A DAY CARE PROGRAM?

- ☐ Yes
- ☐ No

If Yes, ☐ Half Day ☐ Full Day ☐ Special Pre-School

GO TO HEALTH ACCESS FORM

IF THE CHILD IS OLDER THAN 5 YEARS OLD, IS YOUR CHILD ENROLLED IN SCHOOL?

- ☐ Yes – What School? ________________ Grade? ________
- ☐ No

SINCE YOUR HOUSING SITUATION BECAME DISRUPTED, HOW MUCH TIME HAS YOUR CHILD MISSED FROM SCHOOL?

________ Estimated Days / Per Month

WHAT IS THE MOST COMMON REASON YOUR CHILD MISSES SCHOOL?

- ☐ Medical / Health (mh)
- ☐ Medical – Asthma (ma)
- ☐ Family Issues (fi)
- ☐ Psy / Behavioral (pb)
- ☐ Dangerous School Environment (de)
- ☐ Disrupted Living Situation (dl)
- ☐ Transportation Problems (tp)
- ☐ Peer / Teacher Problems (pt)
- ☐ Truancy (tr)
- ☐ Other: (ot) ________________

ARE YOU AWARE OF ANY MAJOR PROBLEMS YOUR CHILD IS HAVING IN SCHOOL?

- ☐ No
- ☐ Yes – ☐ Academic (ac)
  - ☐ Non-Academic (ot)

Detail: ________________

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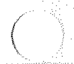
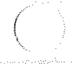

COT 4

Charter Oak Terrace/Rice Health Center
SOCIAL SERVICE INTAKE

Shelter/Referral ______________________ Date ______________ Chart # ______________

Name: ______________________________ D.O.B. __________ Age______ Sex______

Last Address: ____

Medical Insurance: ______________________ Social Security # ______________

Ethnicity: W ☐ B ☐ H ☐ U ☐ O______________________

Educational Background: E ☐ H.S. ☐ College ☐ Grade Level: ______________

Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐

Emergency Contact: ______________________ Rent $__________

Occupation/Background: ____

____

Reason For Consultation: ____

____

____

Source of Income/Amount

Unemployment	$ _______
City Welfare	$ _______
AFDC	$ _______
SSI	$ _______
SSD	$ _______
T19	$ _______
WIC	$ _______
VA Benefits	$ _______
Workman's Comp.	$ _______
Wages/Pension	$ _______
Food Stamps	$ _______
Other	$ _______

Family Members

Name	D.O.B.

Language: ______________________

Family Status

- ☐ Unattached Adult 20+
- ☐ Runaway/Unattached Youth 19 and under
- ☐ Adult 20+ in Family
- ☐ Child 0-19 in Family
- ☐ Head of Household 15-19
- ☐ Unknown

Other Agency Interventions: ____

____

Impressions: (Include Physical Appearance and Attitude: ______________________

____

Treatment Plan (Disposition): ____

____

____

____
Social Worker