Health Care for the Homeless

INFORMATION RESOURCE CENTER

888/429-3300 • Fax 518/439-7612

#6. CLIENT APPLICATION/REGISTRATION

Application for participation (*HOM 2*)
Applicant information summary (*HOM 6*)
Client change form (*TER 7*)
Client information change form (*BIR 11*)
Client registration form (*HCLA 4*)
Documented lack of income (*TER 10*)
Eligibility verification for homeless assistance programs (*BIR 3*)
Patient registration form (*TER 6*)
Patient registration form (*HIP 5*)
Registration form (*CAM 3*)

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

HOM 2

HOMES Inc.

Housing Opportunities Management and Essential Services, Inc.

408 East State Street • Ithaca, New York 14850 (607) 272-1741

Dear Applicant:

OMRDD regulations require that all applicants apply for participation in the Home and Community Based Services Waiver prior to an admission to our program. The process begins by you filling out the attached forms. There are a few items on these forms that may be unclear, so I have written this note to help clarify these things.

Page 1:

* Near the top of the page is a space labelled "Current Address". This is for the address of the HOMES site that you may be admitted into. Please leave this blank. I will fill it in for you.

* Near the bottom of the page is a space labelled "Address". Please fill in the address of where you are while filling out this form.

Page 2:

* There is a space for you to fill in the name of the case manager who you choose to represent you. Since you have not met our case managers yet, please fill in the name Sylvia Taylor who is the supervisor of our case managers. When you start preplacement visits, you will be able to meet all of our case managers and choose who you want to work with.

Page 3:

* On this page, please fill in who you want your advocate to be.
* If you have a legal guardian that person must be your advocate. If you do not have a legal guardian, you can choose anyone to be your advocate except for a HOMES employee.
* This person must be 18 years old and willing to be your advocate.

Please feel free to contact me with any questions.

APPLICATION FOR PARTICIPATION
IN THE OMRDD HOME AND COMMUNITY BASED SERVICES WAIVER

Name of Applicant _____

Current Address _____

_____

Social Security # _____ Date of Birth _____

Medicaid # _____ County _____

[ ] Check here if not currently enrolled in Medicaid

I am requesting participation in the Home and Community Based Services Waiver administered by the New York State Office of Mental Retardation and Developmental Disabilities. I understand that approval will be based on my choice of Home and Community based services in preference to care in an Intermediate Care Facility for the Mentally Retarded and on evidence of:

- developmental disability;
- eligibility for admission to an Intermediate Care Facility for the Mentally Retarded;
- eligibility for Medicaid enrollment;
- availability of appropriate community based services; and,
- appropriate living arrangement.

Applicant Signature: _____

Applicant Name (Print): _____

Assisted by (Signature): _____

Assisted by (Print): _____

Address: _____

_____

Telephone Number: _____ Date: _____

HOM 6-1

COMMUNITY LIVING SERVICES OF H.O.M.E.S., INC.

APPLICANT INFORMATION SUMMARY

(To be completed by applicant with assistance as needed)

Applicant _____ Date _____

D.O.B. _____ SS# _____ Sex _____

Referral Person _____ Relationship _____

Title _____ Address _____

What are your reasons for applying to H.O.M.E.S., CLS Program?

_____

_____

_____

_____

_____

_____

_____

How did you learn about our program? _____

_____

_____

_____

What type of services do you expect to receive here? _____

_____

_____

_____

_____

_____

_____

HOM 6-2

Please describe the reasons you have received psychological/psychiatric care and/or hospitalization.

_____

_____

_____

_____

_____

_____

What do you think you have gained from this or these experiences? _____

_____

_____

_____

If you were you overwhelmed by any of the following:

_____ Depression

_____ Suicidal Feelings

_____ Hearing voices

_____ Wanting to hurt yourself

_____ Wanting to hurt another person

_____ Being scared

_____ Other reality experiences

What would you do? _____

_____

_____

_____

What signs do you experience when you are not feeling well? _____

_____

_____

_____

_____

_____

What do you think you can do or what do you need to help keep yourself out of the hospital?

_____

_____

_____

What medications do you take now? I don't take medications _____

Name	Dosage	Reason Taken

How do you feel about taking medications? _____

_____

_____

What previous independent living services/experiences have you had? (Community group home, day treatment, treatment center, psychotherapy, medications, etc.)

_____

_____

_____

a. What did you like about them? _____

_____

_____

b. What didn't you like? _____

_____

_____

c. What did you get from the program/service? _____

_____

_____

HOM 6-4

d. Did you stop? Yes _____ No _____

If so why did you stop? _____

_____

_____

_____

Family Relationships and Significant Others

Describe your important relationship(s) and why it is important to you (this includes but is not limited to family members, friends, counselors, ministers, spouse, children).

_____

_____

_____

_____

_____

_____

_____

_____

How would you describe yourself right now?

_____

_____

_____

_____

_____

_____

_____

_____

TO BE COMPLETED BY APPLICANT

Before you decide to move to HOMES residence, it is important for you to set some goals by yourself. HOMES is a program which provides a living-learning environment, and you must be willing to work to improve your skills and solve your problems for HOMES to be of value to you. If you are interested in working toward a better, more independent life for yourself, this checklist may help you begin to identify personal goals.

	Would like to learn	Could use some practice	Do pretty well
DAILY LIVING SKILLS			
Meal planning: planning nutritious meals you'll like			
Shopping: recognizing bargains, planning what you'll need			
Cooking: using recipes, measuring foods			
Cleaning; washing dishes, dusting, cleaning bathrooms, and kitchens, mopping floors, vacuuming			
Personal care: grooming, health care			
Laundry: using laundry machines, ironing, mending			
Budgeting: planning ahead, saving for future purchases			
Banking: using savings and checking accounts			
Use of alarm clock			
INTERPERSONAL SKILLS			
Getting along with others			
Expressing your own needs			
Recognizing other people's needs			
Sharing house chores and living space			
Understanding what is important to you (values)			
Deciding what you want in the future (needs, goals)			
Looking at problems and finding useful solutions			
Looking at the results of decisions you make realistically			
Feeling better about yourself			

HOM 6-6

COMMUNITY SKILLS	Would like to learn	Could use some practice	Do pretty well
Telephoning: using phone, directory and operator			
Writing; writing letters, filling out government and job applications			
Learning who to contact and what to do in emergencies			
Locating job opportunities or training programs			
Learning to improve your job skills			
Learning more about your vocational interests and abilities			
Attending your day program regularly and on time			
Finding community services and activities you are interested in (e.g. churches, social groups, sports, theater, etc.)			
Transportation: using buses, taxis, bus schedule			
Learning new ways to use your free time			
Meeting new people and making new friends			

What do you see yourself doing one year from now? (What are the specific goals you have set for yourself?)

What specific behaviors do you wish to acquire or change in order to reach your personal goal?

ADDITIONAL COMMENTS AND RECOMMENDATIONS:

Applicant:

Intake Counselor/Others:

HOM 6-8

I, _____ hereby agree as follows:

1. That I have chosen to be considered for this program voluntarily, and have in no way been threatened or coerced.

2. That I understand and will abide by the rules and regulations set forth in the Housing and fee for Services Agreement and the House Guidelines.

3. That I understand I will be notified by the Admissions/Discharge Committee of my status in regard to the program, and also understand that I will be required to have an interview and visits prior to my admittance into the program.

_____ _____

Applicant's Signature Date

_____

Referring Contact

_____

Title/Agency

AISC.036
U6

TER 7

TERRY REILLY HEALTH SERVICES
CHANGE FORM

****

BATCH NO. REFERENCE _____

ADDRESS CHANGE

RESPONSIBLE PART NAME _____
LAST FIRST MI

PT NAME _____

NEW ADDRESS _____
STREET/PO BOX CITY ST. ZIP

OTHER FAMILY MEMBERS _____,_____,_____,

_____,_____,_____,_____

****

PATIENT CATAGORY CHANGE

PT NAME _____

HOMELESS _____ NON-HOMELESS_____

EFFECTIVE DATE _____/_____/_____

OTHER FAMILY MEMBERS _____,_____,_____,_____,

_____,_____,_____,_____

****

INSURANCE UPDATE

RESPONSIBLE PARTY _____

PT NAME _____

INSURANCE CARRIER_____

SUBSCRIBER NO. _____ EFFECTIVE DATE _____/_____/_____

CANCELED _____ & DATE _____/_____/_____

****

PATIENT CODE CHANGE

RESPONSIBLE PARTY _____
LAST FIRST MI

WISH TO CHANGE PATIENT PAYMENT CODE

TO_____ AS OF _____/_____/_____

INCOME _____

REASON: _____

_____

BIR 11

ACCOUNT NO. _____ (CHANGE.FRM - 6/20/96) CHART NO. _____

****

BIRMINGHAM HEALTH CARE - CLIENT INFORMATION CHANGE FORM

DATE _____ SOCIAL SECURITY NUMBER _____-_____-_____

DESCRIPTION	FROM	TO
CLIENT FIRST NAME		
CLIENT MIDDLE NAME		
CLIENT LAST NAME		
SOCIAL SECURITY NO.		
DATE OF BIRTH		
HOUSING STATUS		
STREET ADDRESS OR SHELTER		
CITY		
STATE		
ZIP CODE		
HOME PHONE NO.		
EMPLOYMENT STATUS		
PLACE OF EMPLOYMENT		
WORK PHONE NO.		
FAMILY MEMBERS IN HOUSEHOLD		
CLIENT INCOME		
HOUSEHOLD INCOME		
BENEFITS RECEIVING		
HEALTH INSURANCE		
POLICY NUMBER		
OTHER:		
_____		
_____		
_____		

COMMENTS:

REASON FOR CHANGE:

PERSON REQUESTING CHANGE _____ DATE _____

DATA ENTRY _____ DATE _____

HCLA 4

HOMELESS HEALTH CARE LOS ANGELES
CLIENT REGISTRATION FORM

TODAY'S DATE_____
STAFF_____

CLIENT NO. _____ ☐ NEW ☐ AMENDED ☐ READMIT
SITE_____

PERSONAL INFORMATION

LAST NAME_____ FIRST NAME _____
MIDDLE INITIAL _____

DOB_____ AGE _____ SOCIAL SECURITY NO. _____/_____/_____ SEX: ☐ MALE ☐ FEMALE

ETHNICITY/LANGUAGE

☐ ASIAN/PACIFIC ISLANDER
☐ AFRICAN AMERICAN (NOT HISPANIC OR LATINO)
☐ AMERICAN INDIAN/ALASKA NATIVE
☐ WHITE (NOT HISPANIC OR LATINO)
☐ HISPANIC OR LATINO
☐ UNKNOWN

☐ NEEDING INTERPRETATION/BILINGUAL/AMERICAN SIGN LANGUAGE SERVICES

HOUSING STATUS

___ LAST NIGHT?
___ 30 DAYS AGO?
___ 6 MONTHS AGO
___ 1 YEAR AGO?
___ TONIGHT?

1 SHELTER
2 TRANSITIONAL FACILITY
3 CAR
4 STREET
5 HOSPITAL
6 HOTEL
7 SRO
8 PRISON/JAIL
9 FAMILY/FRIENDS
10 OWN APARTMENT
12 RESIDENTIAL TX CNT
13 BOARD AND CARE
14 OTHER

IS CLIENT HOMELESS? ☐ YES ☐ NO

INSURANCE/PUBLIC BENEFITS STATUS

☐ MEDI-CAL ☐ MEDICARE ☐ OTHER PUBLIC INSURANCE ☐ PRIVATE INSURANCE

☐ NONE/UNINSURED ☐ CALWORKS ☐ FOOD STAMPS ☐ GENERAL RELIEF ☐ SSI

☐ UNEMPLOYMENT ☐ WAGES/PENSION ☐ WIC ☐ VA

GROSS MONTHLY INCOME_____ FAMILY SIZE_____ % OF POVERTY: A B C D E F

DIAGNOSTIC CONDITIONS

(Circle all that apply)

ACUTE INFECTION
ALCOHOL DEPENDENCE
ANEMIA
CHRONIC MENTAL ILLNESS
CHRONIC RESPIRATORY CONDITION
DENTAL
DEVELOPMENTAL DELAY
DIABETES
DOMESTIC VIOLENCE
DRUG DEPENDENCE
EXPOSURE
GI DISORDERS
HEPATITIS
HIV (INFECTION, AIDS)
HYPERTENSION
INCOMPLETE IMMUNIZATION
INFLUENZA
MENTAL RETARDATION
NUTRITIONAL DISORDER
OTHER REPORTABLE DISEASES
PNEUMONIA
PREGNANCY
ROUTINE HEALTH ASSESSMENT
SKIN DISEASE
STD
TB (PRIOR, NEW, ACTIVE)
TRAUMA

REVISED: 1/2002

TER 10

TERRY REILLY HEALTH SERVICES

"Advancing Health In Idaho"

DOCUMENTED LACK OF INCOME FORM

DATE:_____

TO: THE BOISE CLINIC STAFF

SUBJECT: INCOME VERIFICATION OF HOMELESS AND LOW INCOME PATIENTS

The following patient:_____is unable to provide verification of current income to the staff at the Boise Clinic, Terry Reilly Health Services. I have reviewed and verified income with this patient and hereby acknowledge that he/she is earning $_____per month.

_____
Signature

_____
Relationship to patient or Title

Administration Office
211 16th Ave. N.
Nampa, Idaho 83687
(208) 467-4431
FAX (208) 467-7884

Nampa Clinic
223 16th Ave. N.
Nampa, Idaho 83687
(208) 466-7869
TDD (208) 467-4432
FAX (208) 466-5359

Teen Clinic
1504 3rd Street N
Nampa, Idaho 83687
(208) 467-7654

Homedale Clinic
108 E. Idaho, Box 1058
Homedale, Idaho 83628
(208) 337-3189
TDD (208) 337-3189
FAX (208) 337-4623

Marsing Clinic
201 Main, Box 516
Marsing, Idaho 83639
(208) 896-4159
TDD (208) 896-4159
FAX (208) 896-4917

Caldwell Dental
920 Main
Caldwell, Idaho 83605
(208) 455-2746

— United Way - A Partner in Fund Raising

Boise Clinic
848 LaCassia
Boise, Idaho 83705
(208) 344-3512
TDD (208) 344-3512
FAX (208) 338-1574

SANE Ada
1716 S. Roosevelt
Boise, Idaho 83705
(208) 345-1170
FAX (208) 345-3502

SANE Canyon
1503 3rd Street N.
Nampa, Idaho 83687
(208) 467-7654

BIR 3

ACCOUNT NO. _____ (HOMELESS.FRM - 8/2/96) CHA[illegible] NO. _____

****

BIRMINGHAM HEALTH CARE

ELIGIBILITY VERIFICATION FOR HOMELESS ASSISTANCE PROGRAMS

DATE _____

SOCIAL SECURITY NUMBER _____-_____-_____

DATE OF BIRTH _____

(Print) FIRST NAME _____ MIDDLE NAME _____ LAST NAME _____

ADDRESS (OR SHELTER) _____

CITY _____ STATE _____ ZIP CODE _____ HOME PHONE _____

Please furnish your mail address if you receive mail at some address other than the one stated above: _____

I currently live (please check one of the following):

____ On the streets; How long have you lived on the streets? _____

____ Shelter; How long have you lived in the shelter? _____
Name of Shelter _____
Name of social worker at shelter _____

____ Treatment facility; How long have you lived at the facility? _____
Name of facility _____
Name of social worker / counselor at facility _____

____ Living with relatives or friends; How long have you lived there? _____
Name of relative / friend _____
Relationship _____

____ Rental Housing
Name of Housing Development if applicable _____

____ At RISK of becoming Homeless; Please explain _____

____ Other; Explain _____

Where did you live prior to your current living situation: _____
How long? _____

Income $_____ per _____; Source of Income _____

Client Comments:

I VERIFY THAT I AM HOMELESS OR AT IMMEDIATE RISK OF BECOMING HOMELESS AND THE ABOVE INFORMATION IS A TRUE AND CORRECT STATEMENT OF MY LIVING CONDITIONS AND INCOME.

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

****

INTAKE NOTES:

BY _____

TER 6

TERRY REILLY HEALTH SERVICES

Registration Date ____/____/____
Mo. Day Yr.

PATIENT REGISTRATION FORM

Patient's Name _____ Birth Date _____

Marital Status _____ Phone _____ Age _____ Sex _____

Address _____ City _____ State _____ Zip _____

NAME OF PERSON LEGALLY RESPONSIBLE FOR ACCOUNT _____

Employer _____ Occupation _____

Business Address _____ Phone Number _____

NAME OF FRIEND OR RELATIVE IN AREA _____

Address _____ Phone Number _____

PLEASE COMPLETE: (Circle One)

ETHNIC GROUP: WHITE BLACK HISPANIC OTHER (Optional)

HAS ANYONE IN THE FAMILY WORKED IN AGRICULTURE?
(Fields, Simplot, Orchards, etc.) YES ____ NO ____

DO YOU MOVE AS PART OF YOUR WORK FROM PLACE TO PLACE? YES ____ NO ____

INSURANCE INFORMATION

MEDICARE NUMBER _____ HEALTH & WELFARE NUMBER _____

BLUE CROSS OF IDAHO NUMBER _____ GROUP NUMBER _____

Other Insurance _____ Number _____

Social Security Number _____ Birthdate _____

Subscriber Name _____ Relationship _____

Insurance Address _____

Insurance patients only (EXCLUDING MEDICARE): I authorize the release of any medical information necessary to process my insurance claim. I also authorize payment of medical benefits to Terry Reilly Health Services. I accept full responsibility for all charges due.

Signature _____ Date _____

REDUCED FEE REQUEST

(Only complete if you request a reduction)

Total Gross Income (**Before Taxes**) of the entire household:

Weekly _____ Monthly _____ or Annual _____

I certify this information is true. I authorize you to examine my financial records, if necessary.

Signature _____ Date _____

Family Size _____ (Please list below)

Name _____
Last First M.I. Birthdate Male/Female

Name _____
Last First M.I. Birthdate Male/Female

PAYMENT IS EXPECTED AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

(continued on other side)

	Last	First	M.I.	Birthdate	Male/Female
Name					
Name					
Name					
Name					

TELL US ABOUT YOUR PRESENT LIVING ARRANGEMENTS
(Please Check One)

ARE YOU: Buying ____ Paying Rent ____

LIVING TEMPORARILY WITH:
- Friends ____
- Relatives ____
- In a shelter ____
- On the street ____

TERRY REILLY HEALTH SERVICES does not discriminate against any individual on the basis of race, color, sex, national origin, handicap, or age in treatment or participation in its programs, services, and activities, or in employment. For further information about this policy, contact: Erwin Teuber, Administrator, Phone: 467-4431

HIP 5

PATIENT REGISTRATION: Homeless Initiative Program
1835 N. Meridian Street
Indianapolis, IN 46202 (317) 931-3055

DATE SEEN: ____/____/____
ELIGIBILITY VERIFIED: ____
RELEASE SIGNED: Yes Already on file for year (circle one)

847	848	818		812	815	849	805	810	819	816	845	811	817	820	807	808	806	846	809	842	
SITE: AIB	AP	CC	CP	D	GN	HC	HF	HH	HIP	HL	IHN	JCS	LH	LLDC	MtO	PW	SAFS	St	WM	Phone	OTHER ____

LAST NAME: FIRST NAME: M.I. DOB: ____/____/____ AGE: ____
HOSP #:

SSN: ___ ___ RACE: B W H N/A A/P Other SEX: F M

ADDRESS: VET Y N Other vet in family Y N If Y to either, # children <18___

FAMILY STATUS: UA(S) A:M, 0 Children A: Not M, Children A: M+C (Ages of children _ _ _ _ _) Child YP Y/R Unknown

MOTHER'S NAME:

NEED TO VERIFY INFO BELOW AT EVERY ENCOUNTER

HOUSING: SHl ST TRan DO-u:___
OT:___ UNknown

MEDICAL MAid #___
RESOURCES:MCare#___
PrvInsCo: ___ #___
VAMed: ___
Other: ___ NONE

FINANCIAL RESOURCES: Empl/Pen AFDC SSD SSI Unempl.Ins. WIC WorkComp
FooDStmps Oth.VA.Ben. None Other: ___

INFO BELOW NEEDED ONLY AT 1st HIP ENCOUNTER IN YEAR

HOUSING: Shl ST TRan DO-u:___
DV Sit PsychFacil SubAbuse.trmt.fac Hosp JAil/Prison
Living w/FRiend/FAm RentlHsing Unknown OTher:___

REFERRAL FROM: SELf STOutrch Shl/HsingStff ADProgrm
Hosp/CLlinic MentlHlthOutpt.clnc OtherSocServ.staff
PSychHosp POLice PHAwaitList CHUrch UNKnown
OTHer___

DISABILITIES REPORTED WHEN ENTERING HIP PROGRAM:
severe Mental Illness chronic Alcohol Abusel/Drug Abuse BOth
AIDS/Related Illness None Reported OTher: ___

Previously @ HIP: Y N
To reach at Shelter–SW: ___ Rm___

EMERGENCY CONTACT: ___

ICD-9# (1) ___ (2)___ (3) ___ (4)___ (5)___

Signature, Title, Initials: ___ Provider #___

MEDICAL ENCOUNTER

NEW PATIENT
209 Problem focused
210 Expanded Prob. Foc.
211 Detailed
212 Extended
218 Comprehensive

ESTABLISHED PATIENT
214 Problem Focused
215 Expanded Prob Foc
216 Detailed
217 Comprehensive

NURSING ENCOUNTER
207 Nurse Visit

OTHER
825 HIV Risk
826 IDU

EDUCATION/COUNSELING
821 HIV
823 Substance Abuse
824 Mental Health

IMMUNIZATIONS
703 DPT #1 2 3 4 5
708 OPV #1 2 3 4 5
704 DT (Peds)
710 dT (Adults)
713 Hib #1 2 3 4
707 MMR #1 2
711 Influenza
Other:___
340 TB Skin Test (PPD)

PROCEDURES
507 Suture removal (I-5)
514 Ear lavage L R
506 Wound Care
517 Snellen
523 PEFR
508 Dressing Change
___
___
___

LABORATORY
315 Glucose
420 Beta HCG (Urine)
344 KOH
343 Wet Prep
327 CBC
328 CVC/Diff
407 Hgb
325 Hct
329 Sed rate
336 Latex strep ID
335 Throat culture
308 UA W/micro
309 UA w/o micro
337 Urine C & S
317 Hemocult
409 Lead screen
419 Pap smear

416 GC Culture
412 Chlamydia Screen
348 Specimen collection
300 Drawing fee/Blood
400 Outside Lab___
___
___
___
___
___
___
___

828 Transportation
829 Dental Referral
830 Medical Referral
856 Optometry Referral
831 B/P Check
832 Referral Follow-up
833 Informattion Only

Signaturre:___
Provider # ___

NOTES: _____

C O N S E N T

I do hereby give my permission for the medical staff/dental staff of People's Health Center to treat as they deem necessary, the client named hereon. Where applicable, I assign all Medicaid/Medicare payments and all insurance benefits payable to me for these services to People's Health Center.

Signature: _____ Date: _____ Relation to Patient: _____

Witness: _____ Title: _____ Date: _____

CAM 3-1

Camillus Health Concern, Inc
Registration Form

CHC Medical Record # _____

1. Last name: _____ Middle initial: _____
2. First name: _____ Phone number: _____
3. Address: _____ Zip Code: _____
4. Emergency contact: _____ Phone number: _____
5. Relationship to emergency contact: _____
6. Social Security: _____-_____-_____
7. Country of birth: _____
8. Date of birth: _____/_____/_____ ❑ Female ❑ Male
9. Marital status: _____
10. Nationality: (*Please choose one*)

    ❑ Asian ❑ Black (*Non-Hispanic*) ❑ Hispanic (*All Races*) ❑ White

    ❑ Indian/Alaskan Native ❑ Pacific Islander ❑ Unknown ❑ Other _____
11. Preferred Language _____
12. Are you employed: ❑ Yes ❑ No If yes weekly income $ _____
13. How many people are supported by this income (*including yourself*) _____
14. What type of insurance do you have? (*Please choose one*)

    ❑ Medicaid ❑ Medicare ❑ Medipass ❑ Physicians Healthcare Plan ❑ Not apply
15. Mother's first name: _____
16. Mother's birth last name: _____
17. Father's first name: _____
18. Father's last name: _____
19. Living Situation (*Please choose one*)

❑ Street	❑ Hotel/Motel
❑ Car	❑ Substance Abuse/Treatment Center
❑ Shelter	❑ Apt/House (*less then 12 months*)
❑ Transitional Housing	❑ Apt/House (*more than 12 months*)

Staff Initials: _____

CAM- 3-

CAMILLUS HEALTH CONCERN, INC.

Please complete so that we have the most updated information on you.

Name:_____

Address:_____

TelephoneNumber:Home_____Work_____

Check one of the following:

Do you have Medicaid or Medicare? ____ Yes ____ No

Do you get a check every month? ____ Yes ____ No

Thank You

Por favor complete, para que nosotros tengamos la mas reciente informacion de usted.

Nombre :_____

Direccion:_____

Numero de Telefono:-Casa_____ Trabajo _____

Marque uno de los Siguiente:

Usted tiene Medicaid o Medicare? _____ Yes _____ No

Usted recibe un cheque cada Mes? _____ Yes _____ No

GRACIAS