**Mariam Clinic & Project Access Intake Form Referring Clinic: Mariam Clinic Patient ID#**

 **Person completing form:**  **Phone**:

Primary Language:      ­ Translation Needed [ ] Yes [ ] No ­ Access to Transportation [ ] Yes [ ] No

Full Legal Name:       DOB:       SSN:       -       -       [ ]  None

Physical Address:       Apt/Lot#:      City:      Zip Code:      County:

Mailing Address (if different from physical address):

Preferred Phone #:      [ ] Cell [ ] Home Alternate phone:

**Emergency Contact**:      **Phone (not same as enrollee):** Relationship to patient:      \_

**Gender**: [ ]  Male [ ]  Female [ ]  Transgender

**Marital Status**: [ ]  Single [ ]  Married [ ]  Divorced [ ]  Separated [ ]  Widowed

**Ethnicity**: [ ]  Asian [ ]  Black [ ]  Hispanic [ ]  Middle Eastern [ ]  White [ ] Other:

**Citizenship Status**: [ ]  Citizen [ ]  No legal status [ ]  Permanent Resident <5 Year [ ] Permanent Resident> 5 Years

**Housing Status:** [ ]  Rent [ ]  Homeowner [ ]  Homeless [ ]  Roommate [ ]  Lives with family

**Source of Income:** [ ]  Job [ ]  SSDI & approval date: \_\_\_\_\_\_\_\_\_ [ ]  SSI [ ]  Family Member [ ]  Lives off savings/annuities

|  |
| --- |
| **Please include MONTHLY & YEARLY income for all employed household members** |
| **Who** | **Relationship** | **Name** | **DOB** | **Employer’s Name** | **Monthly** | **Yearly** |
| **Enrollee** | **SELF** | **SELF** |  |  |  |  |
| Spouse |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |

**Additional Required Information**

Does your Employer offer Health Insurance?: [ ] Yes [ ] No If YES, monthly cost of insurance:

**----------------------------------------------------------------- LEAVE AREA BELOW BLANK -----------------------------------------------------------------------**

Diabetic?: [ ] Yes [ ] No Date of last A1C:       Result:

Is there a pending Medicaid Application? [ ] Yes [ ] No If YES, date application submitted:

Medicaid Determination: [ ]  Ineligible [ ] Approved [ ]  Denied If denied/Ineligible, please provider reason:

Specialty Needed:

Medical Reason for Referral: