**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: