New Consumer Intake Form

Date: _____ **Chart #:** _____ **Age:** _____

Our clinic is part of Special Health Resources (SHR), a Federally Qualified Health Center and all information requested is mandated for reporting and statistical purposes. All information is strictly confidential, meaning no identifying information will be released without your consent or otherwise permitted by the law. The information requested allows SHR to evaluate each client for eligibility to its multiple programs; therefore, we request you complete this document thoroughly and truthfully in its entirety.

Patient Information

First Name | Middle Name | Last Name | Date of Birth

Soc. Sec. or ITIN # | Driver's License or ID # | State Issuance | Expiration Date

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐ Separated ☐

Physical Address (*No P.O. Box*), City, State Zip Code | County

Mailing Address, City, State Zip Code | County

Home Phone # | Cell Phone # | Work Phone # and Ext.

E-mail address | Mother's Maiden Name | Gender: Male ☐ Female ☐

Responsible Party

Same as above ☐

First, middle and last name | Soc. Sec. # | Date of Birth

Relationship: Legal Guardian/Parent ☐ Power of Attorney ☐

Mailing Address, City, State Zip Code | County

Home Phone # | Cell Phone # | E-mail

Emergency Contact

First, middle and last name | Physical Address (*No P.O. Box*), City, State Zip Code

Home Phone # | Cell Phone # | E-mail | Relationship

For Funding Sources Data Requirements Only: Confidential Information

Language: English ☐ Spanish ☐ Sign Language ☐ Other ☐ (Specify)_____

Do you need a translator? Yes ☐ No ☐

Ethnicity (check one): Hispanic/Latino ☐ Non -Hispanic/ Latino ☐

Race (check all that apply): Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Black/African American ☐
American Indian/Alaskan Native ☐ More than one race ☐ Decline to report race ☐

Insurance & Sliding Fee Qualification

Insurance Name: _____ Medicare☐ Medicaid☐ Group/Private☐ None☐

Employment Status: Full Time☐ Part time☐ Retired☐ Disabled☐ Self -Employed☐ Public Assistance☐ Not Applicable☐

Policy Holder's (PH) Name	PH Date of Birth	PH Social Security #	Group #

Patient ID #	Employer	Employer Phone #

The Sliding Fee Scale for Family Medicine, Pediatric Services, OB/GYN, Behavior Health and Dental Services Based Only on Family/Household Income and Size, based on the Federal Poverty Levels (FLP) guidelines.

Estimated Household Income: _____ Weekly ☐ Bi weekly☐ Monthly☐ Annually☐

Family Size (including patient) _____ Dependent(s): _____

Identify your family size and please circle the income that best represents your monthly income.
There is a nominal fee for the office visit, and charges for labs and select procedures and medications.

# In Family	*Under or equal to 100% FLP*	*Above 100% FLP*	*Equal 133% FLP*	*Above 133% FLP*	*Equal 166% FLP*	*Above 166% FLP*	*Equal 200% FLP*
1	$1,073	$1,074	$1,428	$1,429	$1,782	$1,783	$2,147
2	$1,452	$1,453	$1,931	$1,932	$2,410	$2,411	$2,903
3	$1,830	$1,831	$2,434	$2,435	$3,038	$3,039	$3,660
4	$2,208	$2,209	$2,937	$2,938	$3,666	$3,667	$4,417
5	$2,587	$2,588	$3,440	$3,441	$4,294	$4,295	$5,173
6	$2,965	$2,966	$3,943	$3,944	$4,922	$4,923	$5,930
7	$3,343	$3,344	$4,447	$4,448	$5,550	$5,551	$6,687
8*	$3,722	$3,723	$4,950	$4,951	$6,178	$6,179	$7,443

*For additional family members, add $378 per person

I qualify for SFS and I would like to apply for it ☐ I qualify for SFS, but I don't want to apply ☐

My household income is equal or above 200% or the Poverty Level and I do not qualify for SFS ☐

Prefer contact method: Home phone☐ Cell phone☐ Email☐

Sexual Orientation: **(this is mandated for patients 18 years old and over)** Heterosexual (or Straight) ☐ Lesbian or Gay ☐
Bisexual ☐ Something else ☐ Don't know ☐ Chose not to disclose ☐

Gender Identity: **(this is mandated for patients 18 years old and over)** Male ☐ Female ☐ Transgender Male-to-Female ☐
Transgender Female-to-Male ☐ Choose not to disclose☐ Other ☐: _____

Structured/Additional Information

Referral source (Marketing): How did you learn about us? (Please select all that apply)*:* Radio ☐ Television ☐ Facebook ☐
Google ☐ Friend/Family ☐ Other: _____

Veteran: Yes☐ No☐

Migrant: Yes☐ No☐ Agriculture Worker? Yes☐ No☐

Public Housing: Yes☐ No☐

Limited English: Yes☐ No☐ Primary Language Spoken at Home: _____

Homeless: Yes ☐ No ☐

Consent to Share: Yes☐ No☐

For Office Personnel Only

Ryan White Participant: Yes☐ No☐

PrEP (Pre-Exposure Prophylaxis): Yes☐ No☐

Source of Payment: No Fee☐ Medicaid☐ Primary Health Care☐ State Family Planning Program (Title X)☐
Full fee☐ Part-Fee☐ Medicaid Managed Care☐
Other ☐ TWHP/Healthy Texas Women (HTW)☐ Private Insurance☐

Entered in eCW by	Position	Date