



INTAKE/ASSESSMENT FORM

Intake Date \_\_\_\_\_ CHW \_\_\_\_\_  
 1. *Fecha de la Encuesta* \_\_\_\_\_ 2. Promotora \_\_\_\_\_

Location  
 3. *Centro* \_\_\_\_\_

Patient #  
 4. Kit # \_\_\_\_\_ 5. *No. de Paciente* \_\_\_\_\_

Patient's Name  
 6. *Nombre del Paciente* \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_  
 7. *Domicilio* \_\_\_\_\_ 8. *Ciudad* \_\_\_\_\_ 9. *Zona Postal* \_\_\_\_\_

Phone Number \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 8. *Numero de Telefono* \_\_\_\_\_ 9. *Fecha de Nac.* \_\_\_\_\_

Social Security Number \_\_\_\_\_ Religion \_\_\_\_\_  
 10. *Numero de Seguro Soc.* \_\_\_\_\_ 11. *Religion* \_\_\_\_\_

Residency \_\_\_\_\_ Number in Household \_\_\_\_\_  
 12. *Estatus Legal* \_\_\_\_\_ 13. *#Miembros en la familia* \_\_\_\_\_

Emergency Contact  
 14. *Contacto de Emergencia* \_\_\_\_\_

(Address/ *Domicilio*) \_\_\_\_\_

(Phone Number/ *Numero de telefono*) \_\_\_\_\_ (Relation/*Relación ó Parentesco*) \_\_\_\_\_

*Estado Financiero*

15. Financial Status

	Name/Nombre	Income/Ingreso	Resources/Fuente Proveniente
1.			
2.			
3.			

	APPROVED APROBADO	PENDING PENDIENTE	DENIED NEGADO	\$ AMOUNT CANTIDAD	CASE # # CASO
Medicaid/SSI					
Medicare					
TANF					
Child Support <i>Sostenimiento para Niños</i>					
Food Stamps <i>Estampillas de Comida</i>					
Other/Otro					

Diagnosis  
 16. *Diagnostico* \_\_\_\_\_

Date of Diagnosis  
 17. *Fecha de Diagnostico* \_\_\_\_\_

Notes: \_\_\_\_\_