ESM Client ID:

Provider ID:

Intake Form
Family Residential & Sober Living Adult

ESM Release of Information: ☐ Yes ☐ No

Enrollment Date: / /
mm dd yyyy

ALL QUESTIONS MARKED WITH A ▶ MUST BE COMPLETED.

1. First Name: **Middle Initial:** **Last Name:** **Suffix:**

▶ **2. Highest Grade Completed:**

☐ Not of school age ☐ High school diploma/GED ☐ College degree or higher ☐ No formal education
☐ Some schooling, no high school ☐ Some college ☐ Other credential (degree, certificate) ☐ Unknown
☐ Some high school ☐ Associates degree

▶ **3. Gender:** Male ☐ Female ☐ Transgender ☐

▶ **4. Birth Date:** / / *mm dd yyyy*

▶ **5. SSN:** *If client refuses to give SSN or it is unknown, enter 999-99-9999*

PERSONAL INFORMATION>ADDRESS Section

▶ **6a. Address Type:** Home ☐ Near Homeless ☐ Homeless ☐ ***See Job Aid in the Intake Manual to determine Homeless vs. non-Homeless!***

If Address Type is "Homeless", only enter the city/town and zip code where client is usually homeless. ***Do not use the Program's city/town/zip.***

▶ Street Address: Unit:

▶ City/Town: ▶ State: ▶ Zip code:

▶ **6b. Is this your Primary Address?** Yes ☒

ALTERNATE NAME Section

If client has an alternate name, complete the following:

7a. First Name: **Middle Initial:** **Last Name:**

7b. Name Type: Alias ☐ Nickname ☐ Known by ☐ Married Name ☐ Maiden Name ☐ Name at Birth ☐ Prior Marriage Name ☐

CLIENT CHARACTERISTICS>DEMOGRAPHICS Section

▶ **8a. Are you Spanish/ Hispanic/Latino?** Yes ☐ No ☐

If 'yes' to Question 8a, complete Question 8b. ***If 'no' to Question 8a, go to Question 9***

8b. Which of the following ethnicities best describes you?

_____ Central American
_____ Cuban
_____ Dominican
_____ Mexican, Mexican American, Chicano
_____ Puerto Rican
_____ Salvadoran
_____ South American
_____ Unknown
_____ Other, specify _____

If 'no' to Question 8a, Select one from below

9. What is your primary Ethnicity/Ancestry? *(select one only)*

_____ African
_____ African American
_____ American
_____ Asian Indian
_____ Brazilian
_____ Cambodian
_____ Cape Verdean
_____ Caribbean Islander
_____ Chinese
_____ Eastern European
_____ European
_____ Filipino
_____ Haitian
_____ Japanese
_____ Korean
_____ Laotian
_____ Latin American Indian
_____ Middle Eastern
_____ Portuguese
_____ Russian
_____ Thai
_____ Vietnamese
_____ Unknown
_____ Other, specify _____

10. What is your race? *(check all that apply)*

_____ American Indian/Alaskan Indian	_____ Native Hawaiian or Pacific Islander	_____ Unknown
_____ Asian	_____ White	_____ Refused
_____ Black, African American	_____ Other, specify: _____	

11. In what language do you prefer to read or discuss health related materials?

_____ American Sign Language	_____ Haitian Creole	_____ Russian
_____ Cambodian (Khmer)	_____ Hmong	_____ Spanish
_____ Cape Verdean Creole	_____ Korean	_____ Vietnamese
_____ Chinese	_____ Laotian	_____ Other, specify _____
_____ English	_____ Portuguese	

HOUSEHOLD CHARACTERISTICS Section

12. Number of Adults in Household: *(if client is Homeless, enter 1)*

13. Number of Children Living in Household *(children under 19)*: *(children currently living with the client whether or not related)*

14a. Client Income: $

14b. Income Frequency: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annually

15. Source of Income: *(Check all that apply)*

_____ Wages/Salary	_____ Veterans Disability Payment	_____ Retirement - Social Security
_____ Child Support	_____ Private Disability Payment	_____ Retirement/Pension - Private
_____ Alimony	_____ Public Assistance - TANF	_____ Veterans Pension
_____ Disability	_____ Public Assistance - General	_____ Non-employment Cash Income
_____ Disability - SSI	_____ Unemployment Compensation	_____ None
_____ Disability - SSIDI	_____ Workers Compensation	_____ Other

16. Received Income Verification: ☐

17. Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Significant Partnership Rlat.

INSURANCE Section (Data Entry: To get to Insurance section, return to Face Sheet and select Insurance link on left side of screen.)

18. Insurance Type:

☐ **Uninsured**	☐ **MC** (Medicaid / MassHealth / MBHP	☐ **MP** (Medicare –Over 65-some disabled)	☐ **VA** (Veterans Administration)
☐ **HM** –(HMO) (Private HMO – through employment or client pay)	☐ **CI** (Private Insurance – through employment or client pay with no subsidy)	☐ **OT** (Other - Includes State subsidy – ConnectCare / Health Safety Net)	

Insurance Company Name: *Not required if uninsured* | Policy Number:

Data Entry:
If entering a New insurance record, enter the Enrollment Date as the Insurance Effective Date.
If existing client with new insurance, end date previous insurance record with day before this Enrollment Date
If existing client and the insurance has Not Changed since the client's last enrollment (whether or not at your program), simply hit SAVE!!!

19. Is this your Primary Insurance? Yes ☐ No ☐

If the client has additional insurance coverage, complete the following. If not, intake is complete.

20. Insurance Type: **Note: Uninsured is not an option here under additional insurance.**

	☐ **MC** (Medicaid / MassHealth / MBHP	☐ **MP** (Medicare –Over 65-some disabled)	☐ **VA** (Veterans Administration)
☐ **HM** –(HMO) (Private HMO – through employment or client pay)	☐ **CI** (Private Insurance – through employment or client pay with no subsidy)	☐ **OT** (Other - Includes State subsidy – ConnectCare / Health Safety Net)	

Insurance Company Name: | Policy Number:

Note: Relations are captured on Children's Intakes