

**To be completed by
Adult, Parent, or
or Legal Guardian**



Family Intake / Screening Form

**Please return this
form to
Registration**

Section 1. Demographic Information

Mailing Address:	City, State, Zip:	**Home Phone #:
Street Address:	City, State, Zip:	**Alternate Phone # (cell, work):
Homeless Status: <input type="checkbox"/> Not Homeless <input type="checkbox"/> Doubling Up <input type="checkbox"/> Shelter <input type="checkbox"/> Street <input type="checkbox"/> Transitional		**Email:

Section 2. List All Members of your Household

First and Last Name (Please list yourself and anyone you are responsible for)	Date of Birth	Gender	Social Security #	Relationship	Age	Race - American Indian/Alaska Native (please list tribe), Asian/Pacific Islander, Black, White, More than one Race, or Other/Unknown	Ethnicity Hispanic or Latino? Yes or No	Language Assistance Required? Yes or No	Veteran Yes or No
1									
2									
3									
4									
5									
6									
7									
8									

Section 3. Emergency Contact (for clients listed above)

Name:	Relationship:	Phone #
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** We will use these phone numbers and/or email addresses to communicate with you. If you wish us to use a different number or method, please check this box and tell us how to contact you: _____ . You may change this options at any time.

Complete eligibility information on reverse side

Section 4. Gross Combined Monthly Household Income (Income before taxes and other deductions)

Employment	\$ _____	Cash Aid	\$ _____	Employer/Spouses Employer _____ _____
Unemployment	\$ _____	Child Support	\$ _____	
Disability	\$ _____	Retirement	\$ _____	
Social Security	\$ _____	Other Income	_____	
				Is any of this income seasonal? Yes or No

Section 5. Property (information needed to determine eligibility for other coverage's)

Do you own real estate other than the home you live in?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have more than \$3,100.00 in your bank accounts?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have Retirement, CDs, IRAs or Investments? Estimated Value \$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you have Health Insurance, Medicare, Medi-Cal, Partnership, etc. please present your card at check-in

Section 7. Authorization and Release of Information

Under penalty of perjury I hereby certify that the information provided on this form is true and correct to the best of my knowledge.

I hereby authorize the release of any information for verification purposes and to determine eligibility for services at United Indian Health Services (UIHS). I further authorize UIHS to release any information, including diagnosis of health conditions required to process a claim to third party insurance carriers for myself and/or my family members listed on this form. I hereby authorize my insurance benefits to be paid directly to UIHS for services rendered to myself and/or my family members listed on this form. **I may be asked to provide verification of income, residency, bank accounts, or any real property that I own.**

Signature: _____

Date: _____