GHCCM Client Intake Form

Today's Date ___________ Interviewer ____________________________

DO YOU HAVE MEDICAID, MEDICARE, VA BENEFITS or any 3rd party HEALTH INSURANCE? ☐ YES ☐ NO

Last Name ______________________ First Name ______________________

Date of Birth ______________________ Social Security Number ______________________

Street Address 1 ______________________ Street 2 ______________________

City ______________________ State __________ Zip ______________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Emergency Contact ______________ Relation to patient ______________ Phone No. ______________

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Common Law Marriage

Race ☐ White ☐ Black ☐ Hispanic/Latino ☐ Asian ☐ Pakistan ☐ Other __________________

Sex ☐ Male ☐ Female ☐ _________

Is patient: ☐ Veteran ☐ US Citizen ☐ US Resident ☐ Head of Household ☐ Ineligible for Services

Are you currently employed? ___ No ___ Yes _________________________ _____________________________

Employer Spouse's Employer

Highest Grade Completed ____________________ # in Family __________ # of Children ___________

List household members showing on your federal tax form

	Patient	Spouse/Partner	Child	Child	Child	Child
Name						
Date of Birth						
Wages	$	$				
Child Support/Alimony	$	$				
Disability	$	$				
Social Security	$	$				
Retirement	$	$				
Unemployment	$	$				
Food Stamps	$	$				
VA Benefits	$	$				
Self-Employment	$	**$**				
Contributions	$	**$**				
Total	$	**$**				
Combined Total	$	**$**				

Attestation:

- I will notify Greater Hickory Cooperative Christian Ministries of any changes in insurance or household income within one (1) week of change.
- I attest that all statements recorded on this document are true and correct to the best of my knowledge. I authorize the review of my records by representatives of the pharmaceutical companies supplying my medication(s).
- I give my permission to GHCCM to obtain medications on my behalf through the Prescription Assistance Program. My signature on this form indicates my permission for GHCCM to sign the required forms for me.

Applicant's/Representative's Signature: ____ Date: _______

Intake Representative/Caseworker's Signature: ____ Date: ______

Attachments: ___ Photo ID ___Social Security card ___ Proof of Address ___ Contribution toward Expenses form
___ Verification of Income ___ Tax Forms (1040) ___ Medicaid Denial document

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