Mariam Clinic & Project Access Intake Form **Referring Clinic: Mariam Clinic** **Patient ID#**

Person completing form: **Phone**:

Primary Language: _____ Translation Needed ☐Yes ☐No

Full Time NC Resident ☐Yes ☐No Access to Transportation ☐Yes ☐No

Full Legal Name: _____ DOB: _____ SSN: _____ ☐ None

Physical Address: _____ Apt/Lot#:____ City:_____ Zip Code: _____ County:

Mailing Address (if different from physical address):

Preferred Phone #:_____ ☐Cell ☐Home Alternate phone:

Emergency Contact:_____ **Phone (CAN'T BE THE SAME AT THE PATIENT)** _____ Relationship to patient: _____

Gender: ☐ Male ☐ Female ☐ Transgender
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Ethnicity: ☐ Asian ☐ Black ☐ Hispanic ☐ Middle Eastern ☐ White ☐Other:____
Citizenship Status: ☐ Citizen ☐ No legal status ☐ Green Card Issue date:
Housing Status: ☐ Rent ☐ Homeowner ☐ Homeless ☐ Roommate ☐ Lives with family
Source of Income: ☐ Job ☐ SSDI & approval date: _____ ☐ SSI ☐ Family Member ☐ Lives off savings/annuities

LIST **ALL** MEMBERS OF YOUR HOUSEHOLD
INCLUDE MONTHLY & YEARLY INCOME FOR ALL EMPLOYED HOUSEHOLD MEMBERS

Who	Relationship	Name	DOB	Employer's Name	Monthly	Yearly
Enrollee	**SELF**	**SELF**				
Spouse						
Other						
Other						
Other						
Other						
Other						
Other						

Additional Required Information

Does your Employer offer Health Insurance?: ☐Yes ☐No If YES, monthly cost of insurance:

---------- **LEAVE AREA BELOW BLANK**----------

Diabetic?: ☐Yes ☐No Date of last A1C: _____ Result: _____

Is there a pending Medicaid Application? ☐Yes ☐No If YES, date application submitted:

Medicaid Determination: ☐ Ineligible ☐Approved ☐ Denied If denied/Ineligible, please provider reason:

Specialty Needed:

Medical Reason for Referral: