Health District
OF NORTHERN LARIMER COUNTY

Intake Form

Please complete the following information about the *Primary Contact*:

Legal Name: _____ **Date:**_____
First MI Last

Social Security Number:_____-_____-_____ **Date of Birth:**_____ **Age:**_____ **Sex:**_____

Marital Status ☐ Single ☐ Married ☐ Separated/Divorced ☐ Widowed

Email Address_____ **Message Okay?** ☐ Yes ☐ No

Primary Phone (_____)_____**(Home/Work/Cell)** **Message Okay?** ☐ Yes ☐ No

Alternate Phone (_____)_____**(Home/Work/Cell)** **Message Okay?** ☐ Yes ☐ No

Address _____ ☐ **Own** ☐ **Rent**

City _____ **State** _____ **Zip** _____

Mailing Address (if different than above) _____

What is your race or ethnicity? (Please check one):

☐ White, non-Hispanic
☐ African American or Black
☐ Hispanic or Latino
☐ Asian, Pacific Islander
☐ American Indian, Eskimo/Aleut, Alaska Native
☐ Other _____

Preferred Language: ☐ English ☐ Spanish Other:_____

Employment Status: ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Self-Employed ☐ Unemployed ☐ Retired

Do you or anyone in your household work for an employer with 10 employees or less? ☐ Yes ☐ No

Are YOU applying for health coverage? ☐ Yes ☐ No

What is your current health coverage?_____

Primary Care Provider Information

Do you have a regular doctor? ☐ Yes ☐ No Doctor's Name _____

Do you have a regular dentist? ☐ Yes ☐ No Dentist's Name _____

How did you hear about us?

☐ Radio
☐ Television
☐ Print Media, Newspaper
☐ Mail
☐ Internet Search
☐ Social Media - Facebook/Twitter
☐ Health Care Provider
☐ Word of Mouth
☐ Healthcare.gov
☐ ConnectforHealthCO.com
☐ Medicaid Office
☐ Community Organization
☐ Event
☐ Agent/Broker
☐ Repeat Customer
☐ Other_____

The Health District is committed to lowering rates of suicide. To do this, we screen everyone for thoughts of suicide in order to better offer resources and support. Thank you for taking the time to fill out the below.

Recently, have you had little interest or pleasure in doing things? ☐ Yes ☐ No

Have you been feeling down, depressed, or hopeless? ☐ Yes ☐ No

Continued on the next page.

Please complete the following information about the rest of your *Household*:

Legal Name	Relationship	Date of Birth	Sex	SSN (if applying for health coverage)	Race	Employment Status	Current Insurance Type	Tax Dependent?	Applying for Health Coverage?
						☐ Full Time ☐ Part Time ☐ Seasonal ☐ Self-Employed ☐ Unemployed ☐ Retired		☐ No ☐ Yes	☐ No ☐ Yes
						☐ Full Time ☐ Part Time ☐ Seasonal ☐ Self-Employed ☐ Unemployed ☐ Retired		☐ No ☐ Yes	☐ No ☐ Yes
						☐ Full Time ☐ Part Time ☐ Seasonal ☐ Self-Employed ☐ Unemployed ☐ Retired		☐ No ☐ Yes	☐ No ☐ Yes
						☐ Full Time ☐ Part Time ☐ Seasonal ☐ Self-Employed ☐ Unemployed ☐ Retired		☐ No ☐ Yes	☐ No ☐ Yes
						☐ Full Time ☐ Part Time ☐ Seasonal ☐ Self-Employed ☐ Unemployed ☐ Retired		☐ No ☐ Yes	☐ No ☐ Yes
						☐ Full Time ☐ Part Time ☐ Seasonal ☐ Self-Employed ☐ Unemployed ☐ Retired		☐ No ☐ Yes	☐ No ☐ Yes

Sometimes we host focus groups to gather feedback about health insurance topics. Would you potentially be interested in participating in a focus group in the future? (You would be compensated for your time.) ☐ **Yes** ☐ **No**

Sometimes the Health District asks its clients about their experience with the services they received during a recent visit. If you DO NOT wish to be contacted for this purpose, please check the following box. ☐

Internal Use Only

Family glitch:

- ☐ Employer-Sponsored Coverage offered?
- ☐ Affordable/Minimum Value?

Tax Questions:

- ☐ Filing Taxes?
- ☐ If married, filing jointly?
- ☐ If client received APTC in the past year, filed taxes for the previous tax year?

Internal Use Only

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