

INTAKE/ ADMISSION FORM

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Materials offered: Beneficiary Handbook Grievance Process Beneficiary Handbook Grievance Process Provider Directory State Fair Hearing
Provider Directory
Admission Date:
Client Address: Emergency Contact Name: Relationship: Phone: HEALTH INSURANCE Medi-Cal
Emergency Contact Address: HEALTH INSURANCE
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Medi-Cal Medi-Cal Medicare Mone M
Medi-Cal
Medi-Cal
Contra Costa Health Plan (CCHP) Medi-Cal
Other Health Care Information
FINANCIAL INFORMATION Gross Monthly Income (Except for Foster Care Children) \$ Additional Monthly Income \$ Total Assets \$ Court Ordered Expenses \$ Number of Dependents: EDUCATION & EMPLOYMENT INFORMATION Currently enrolled in school or a job training program? No Yes Details: Employment Status: Part-time (<35 hrs) Full-time (>35 hrs) Unemployed (looking for work) Unemployed (not looking for work) Has never been employed in the past Has been employed in the past Interested in a referral for vocational services or school enrollment
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Any additional details:
If currently employed, can you describe the job/work that you do?
If previously employed, can you describe the job/work that you did?
Are you pregnant? \square No \square Yes Due Date: If yes, which trimester: \square 1 st \square 2 nd \square 3 rd
Are you receiving prenatal care? No Yes
Any complications? ☐ No ☐ Yes If yes, please explain:
Any additional relevant details (including prenatal care you may be receiving):
FOR PERINATAL & PARENTING WOMEN PROGRAMS: Do you have any child care needs? No Yes