Client Annual Intake/Financial Worksheet

Please print full legal name:

Last Name_____ First Name _____ MI. ___ Birth Date ___/___/_____

Maiden or Previous Name _____ Gender: ___Female ___Male

Address _____City_____ Zip Code_____

Primary Phone _____ Secondary Phone _____

E-mail address (optional) _____

May we contact you at the above address? Yes No

May we contact you at the above phone number(s) Yes No

If NO, how may we contact you? _____

Would you like reminders sent to you by text? Yes No

Please mark all of the following that apply to you:

MARITAL STATUS: Single____ Married ____ Other _____

RACE ____White ____Black or African American ____American Indian/Alaskan Native ____Asian

____Native Hawaiian/Pacific Islander Other _____

HISPANIC/LATINO ORIGIN: ___Yes ___ No **ENGLISH AS PRIMARY LANGUAGE:** ____ Yes ____ No

EMPLOYMENT STATUS: ___ Full Time ___ Part Time ___Other

EDUCATION: ___ Full Time Student ___Part Time Student ___Other

EDUCATION LEVEL COMPLETED: _____

HEALTH COVERAGE

____Medicaid/KanCare _____Medicare __Other public insurance ____ Private Insurance

____Uninsured Name of Insurance Company_____

Did you verify coverage with your insurance provider? ____Yes ____No

Guarantor: (if different from above)

Last Name _____ *First Name* _____ *Date of Birth* _____

Address _____ City _____ State ____ Zip _____

Relationship to Patient ____ _____ Primary Phone _____

Business Name (if applicable) __ _____

Please list all persons living in the household (Spouse, parents, brother/sister, friends, etc) Give Income Information for All Employed in Household, *including yourself*.

First and Last Name	Age	Relationship	Hours/ Week	$ Per Hour	OFFICE USE ONLY		Type of Verification		
					Calculations	Total Income	CS	Taxes	Initials

If you receive any of the following, please write the amount you receive PER MONTH

Income Source	Yes	No	Amount		Income Source	Yes	No	Amount	
Alimony					Pensions/Annuities				
Child Support					Interest/Dividends				
Foster Child Support					Social Security				
Veteran Pension					SSI				
Unemployment Comp					Aid for Dependent Children				
Workman's Comp					Assistance from Parents				

I certify that the information provided on this form is correct to the best of my knowledge.

_____ _____

Signature Date

I, the client, **decline** to provide income information and will pay full cost for the services.

_____ _____

Signature Date

FOR STAFF ONLY: Level _____

Documentation Type _____ Document Date _____

Primary Language: _____Speaks/Understands English _____ Other language (Interpreter services used)

_____ _____

Signature of Staff Date