Client Demographic Questionnaire

Prefix _______ **First Name** _______________________ **Middle Initial** _________ **Last Name** ____________________________ **Suffix** ________

Email ____ **SSN** ________________________________ **Date of Birth** ______________

Home phone ____ **Other phone** ____

Street Address ____

PO Box or Mailing Address if different than above ____

City ____ **State** _______________________________ **Zip** _______________

Have you ever received treatment from Northeastern Center before? Yes No **If yes, when** ___________________________________

List other names used (maiden name, alias, nickname, preferred name)____

Primary Care Physician Name and Address:

____

____

Who referred you for services? ____

Emergency Contact name ____ **Relationship** ___________________________________

Emergency Contact Address ____

Emergency Contact Phone ________________________

County of Residence: _____________________________ **County of Financial Responsibility:** _________________________

Gender at birth:

Female

Male

Other

Pronoun:

She/Her

He/Him

They/Them

Other

Gender Identity:

Female

Male

Female to Male transition

Male to Female transition

Not sure/questioning

Non-binary

Genderqueer/Neither exclusively Male or Female

Prefer not to answer

Other: ______________

Sexual Orientation:

Lesbian/Gay/Homosexual

Straight/Heterosexual

Bisexual

Don't know

Other: _______________

Ethnicity:

Cuban

Latino, Unknown Origin

Mexican

Not Hispanic or Latino

Other Hispanic or Latino

Puerto Rican

Unknown Ethnicity

Race:

American Indian and Alaskan Native

Asian

Black/African American

Native American or Other Pacific

Other Single Race

Unknown

White/Caucasian

Marital Status:

Single

Married

Divorced

Widowed

FA0156
Origination: 3/18/92
Reviewed: 01/1/2024 Revised: 01/1/2024

Primary/Preferred Language:

Arabic

Dutch

English

Spanish

Other: _____________

Hispanic Origin:

Puerto Rican

Mexican

Cuban

Other Hispanic

Unknown

Ability to Read/Write:

Both

Read only

Write only

Limited both

Limited read

Limited write

Please list any transportation or special needs accommodations needed:

____

____

Annual Household Income: _______________

Number of Dependents: ___________

Number in Household: ________________

Source of Income:

Wages/Salary

Public Assistance

Disability

None

Unknown

Living Arrangements:

On the Street or Homeless Shelter

Private Residence, Independent

Private Residence, Dependent

Jail or Correctional Facility

Institutional Setting

24-hour Residential Care

Adult or Child

Currently Pregnant:

Yes

No

N/A

Educational Status:

Current: Regular Education

Current: Special Education

Alt Education (HS Degree)

Continuing Education

Vocational Training

Not Currently Enrolled

Highest Grade Level Completed:

Elementary School

JR High/Middle School

High School

Some college

Technical/Trade School

2-year college

4-year college

Graduate Degree or higher

Military Status: Yes No

Veteran Status: Yes No

Employment Status:

Employed Full-Time

Employed Part-Time

Unemployed – Seeking work

Unemployed – Not Seeking work

Supported/Transitional Employment

Homemaker

Student

Retired

Disabled Not in Workforce

Ages 0-5

Other Not in Workforce

Unknown

Criminal Justice Involvement:

Probation

Dept. of Youth Services Commitment

Dept. of Corrections

Jail

Parole

Not involved

Smoking Status:

Never

Former

Current - Packs per day _______

Employer Information: ____

Insurance Company ____ **Member ID** __________________________________

Policy Holder: ___________________________ **Effective Date** ________________________________ **Insured SSN** _______________________

Insured Date of Birth ______________ **Group Number** ________________________________

Person to be billed name and address if different than above

____

____

Financial Attestation

I (applicant) hereby declare that anyone listed on this application listed as "no income received" does not receive any income from any source. (*Please initial)* _________

I (applicant) understand that providing false information will result in termination of services and the Northeastern Center may refer documents to an appropriate federal agency for further investigation. (*Please initial)* _________

I (applicant) understand that I must renew this application annually or if there is a change in the number of people in my household or the household income status changes. (*Please initial)* _________

I certify that the family size and income information shown above is correct. I understand that copies of tax returns, pay stubs, and other information verifying income documentation <u>is</u> required <u>before</u> a discount will be approved. (*Please initial*) __________

I understand that the Center reserves the right to establish which services I am eligible for assistance and the conditions under which assistance will be granted. (*Please initial*) __________

I understand the Center charges both a professional and facility charge for all eligible services and that third party copays and deductibles may be applicable to both sets of charges. (*Please initial*) __________

I understand I may be provided services in my absence for which I am responsible for payment (e.g. treatment planning). (*Please initial*) __________

I understand the Northeastern Center, Inc., reserves the right to use established collections procedures if I do not meet my payment responsibility. I authorize the Center and/or any entity authorized by the Center, including those using automated dialing systems, automated messages, email, text messaging and other electronic communication to contact me for any reason using any telephone number, email address and/or mailing address provided. (*Please initial*) __________

I authorize payment directly to Northeastern Center, Inc. for any third party benefits to which I am entitled. I also authorize the release of information to process third party claims. (*Please initial*) __________

I authorize Northeastern Center, Inc. to file a written complaint with the Insurance Commissioner if any insurance claim filed on my behalf isn't paid or denied within thirty (30) days of filing. (*Please initial*) __________

I understand that certain services may not be covered by my insurance, Medicare or Medicaid. I agree to accept financial responsibility for these services. (*Please initial*) __________

I understand any third-party payment will be applied first to the assisted portion of my balance and any payment remaining after the assisted portion has been fulfilled will be applied to my fair share. (*Please initial*) __________

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by Northeastern Center, including physician services. (*Please initial*) __________

I authorize holder of medical or other information about me to release to the Health Care Financing Administration and its agents, including information needed to determine these benefits for related. (*Please initial*) __________

Signature of Patient / Head of household / Guardian: ____

Printed Name: ____

Date: _____________________

Signature of Northeastern Center Representative: ____________________________________

Date: _______________________