YOU CAN BEGIN AGAIN

P.O. Box 472823 Aurora CO 80040
2401 SE 11th St. Topeka KS 66607
Tina Carter, Founder/Executive Director

DATE:_____

Intake Form:

Name:_____
First Last

Mailing Address:_____

E-Mail Address:_____

Telephone No.:_____
(home) (work) (cell)

Best Time to Reach You:_____Okay to Leave Message: Yes No

Please describe your current challenge/concerns:_____

_____

_____

_____

What benefits do you desire from our work together:_____

_____

_____

_____

What are your interests and passions:_____

_____

_____

_____

Confidential Intake Form

Social Security Number	Age	Date of Birth
Sex	Race	Marital Status
U.S. Citizen Yes No	If no, what is your status	
Education: High School Undergraduate Vocational/Technical Post Graduate Other:		
Literate Yes No	If no, explain	
Secondary Language	Religious Preference	

Other individiuals in the home:	
Name	**Relationship**

Who is the person you are closest to?
How is your relationship with your family?

Do you have any children? ☐ Yes ☐ No
If yes, describe your relationship with them. If a minor child, what relationship do you have with your parents/guardian?

_____

_____

What is your mode of transportation?

- Own transportation ☐
- Own transportation but may lose ☐
- Public transportation ☐
- Access to private transportation ☐
- None ☐

Section II. Employment and Disability Benefits

What is your employment status? _____

List your last or current occupation:_____

Does employer have a disability plan? Yes No
Have you applied for disability benefits? Yes No
If yes, what type?_____

Date of application_____Date_____

Financial:
Gross Monthly Income: $_____Source:_____

Monthly expenses:_____

_____

_____

_____

_____

Section III. Medical

Insurance/Health Care Benefits

Name of Insurer			
Street Address	City	State	Zip
Telephone Number	Case or Policy Number	Effective Date	
Name of Insurer			
Street Address	City	State	Zip
Telephone Number	Case or Policy Number	Effective Date	

Are you enrolled in an experimental drug trial? Yes No

If yes, please provide the name of the drug, the medical provider and telephone number.

_____

_____

_____

Date of first positive HIV Test:_____

Have you been diagnosed with AIDS? Yes No Estimate time of Infection:_____

Latest CD4+Count Date:

Latest Viral Load: Date:

Other significant history:_____

_____

_____

_____

_____

_____

Medications
List any medications you take regularly.

Name	Dosage/Day	Cost	Method of Payment

_____

_____

_____

_____

Confidential Intake Form

**********Staff use Only**********

Battery of Tests:_____

Intake Signature:_____ Date:_____

Client Signature:_____ Date:_____

You Can Begin Again's board, staff, volunteers, and programs are open to all racial and ethnic backgrounds. The current board is a reflection of the organization's surrounding community; staff and volunteers will be selected on similar grounds. You Can Begin Again values diversity and understands the role of participation and inclusion in the effectiveness of the organization.