RPMS Intake Form

Please Complete Front and Back. *** Print Clearly and Legibly. ***

Chart Number__________________ Date______________________________

Name: ______________________________________ Alias: __________ Internet Access: Yes/No Where:
Last First Middle E-mail:__________________
Address:_________________________________ Home#: ( )____________ Cell#: ( )______________

____ Date of Birth:__________ Age:______ Sex: M / F
City State Zip Code
Date you moved to the Salt Lake Area:______________________ Place of Birth:_______________________
City State
SSN:____________________ Marital Status (circle): Single Married Separated Divorced Widow Never Married

Indian Blood Quantum (circle): 4/4 1/2 1/4 1/8 1/16 Other:_____________

Tribe:________________ Agency: ______________________ Tribal Enrollment Number:_______________

Tribe Quantum (circle): 4/4 1/2 1/4 1/8 1/16 Other:_____________

Other Tribe/Race:____

Enrollment Pending: ______ Date of Request:_____________

Descendant of Enrolled Member:__________ Birth Certificate Provided Y / N Mother / Father

Father's Name:______________________________ Tribe:____________ Birth:_______________________
Last First City State
Mother's Maiden Name:_________________________ Tribe:____________ Birth:_______________________
Last First City State

List Household Members: Name, DOB, Age, M/F, Relationship: Household #:__________ # of Income: __________

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Employed (circle): Y / N / Retired If Yes (circle): Part-Time / Full-Time / Seasonal

Employment (gross monthly):_________________ Employer:______________________________________

Address:________________________________ Phone: ( )_______________ How Long w/Job:_________
Street City Zip Code
AFDC_____ FS_____ SS______ SSI________ Unemployment__________ VA____ Child/support/Other__________

Student: Y / N - PT / FT Do You Receive: Pell Grant____ Scholarship____ Tribal Grant_____ Loan_____ Other_____

Where Do You Go To School?_________________________ For How Long?__________________________

Disabled: Y / N Veteran: Y / N Military: Y / N Religious Preference:____________________

Spouse/Significant Other Employed (circle): Y / N / Retired   If Yes(circle): Part-Time / Full-Time / Seasonal

Employment (gross monthly):_____________________ Employer:____

Address:______________________________________ Phone: (   )______________ How Long with Job:________

AFDC_____ FS_____ SS______ SSI________ Unemployment__________ VA____ Child/support/Other__________

Student: Y / N - PT / FT Do You Receive: Pell Grant____ Scholarship____ Tribal Grant_____ Loan_____ Other_____

Where Do You Go To School?____________________________ For How Long?_____________________________

Emergency Contact / Next of Kin Information:

1. Name:____ Relationship:_____________________________________
First Last
Address:____ Phone #: (   )_______________
Street City State Zip

2. Name:____ Relationship:_____________________________________
First Last
Address:____ Phone #: (   )_______________
Street City State Zip

Do you have Medicaid Coverage: Yes / No CHIP/PCN/UPP Coverage: Yes / No Applied: Y / N When:__________
If yes:
Type (circle): Traditional / Non-Traditional State: ___________ Medicaid Number: _______________________

Name of Insured Person: ____ Relationship:__________________

Eligibility Date: _____________________ Eligibility End Date:_____________________

Do you have Medicare Coverage: Yes / No
If yes: Insurance number: __________________ Eligibility Date: _____________________ Coverage: A B

Do you have Railroad Retirement Coverage: Yes / No
If yes: Insurance number: __________________ Eligibility Date: _____________________ Coverage: A B

Do you have Private Insurance Coverage: Yes / No Medical: Yes / No Dental: Yes / No Type: Single / Family
If yes for Medical:
Insurance Name:________________________ Policy Number: _________________ Eligibility Date:____________

Address:____ Group Name:_____________________
Street State Zip
Name of Insured Person: ____ Relationship:___________________

If yes for Dental:
Insurance Name:________________________ Policy Number: _________________ Eligibility Date:____________

Address:____ Group Name:_____________________
Street State Zip
Name of Insured Person: ____ Relationship:___________________

Office Use Only:
Intake completed by:____ Date:_____/_____/____________

CIB_______ Photo ID____ SSN_________________________

Proof of Residence_________________________ Employer's Info_______________________ Copy of Ins_________

Contacts______________ HIPPA Signed & Date_______________________________ GIPRA___________