

# PROJECT MEND INTAKE APPLICATION

DURABLE MEDICAL EQUIPMENT SERVICE

FITTED MOBILITY SERVICE

DATE			REFERRED BY		
NAME		COUNCIL DIST. #		PRECINCT#	
ADDRESS			COUNTY		
CITY	STATE	ZIP CODE	DATE OF BIRTH		AGE:
TELEPHONE			SOCIAL SECURITY #		
DIAGNOSIS		MR #	HEIGHT		WEIGHT

### CLIENT DEMOGRAPHICS

*(Please check appropriate box)*

GENDER	Male	<input type="checkbox"/>
	Female	<input type="checkbox"/>
	Female Head of Household	<input type="checkbox"/>
VETERAN, MILITARY PERSONNEL, FAMILY MEMBER	YES	<input type="checkbox"/>
	NO	<input type="checkbox"/>
AGE GROUP	0-18	<input type="checkbox"/>
	19-34	<input type="checkbox"/>
	35-59	<input type="checkbox"/>
	60+	<input type="checkbox"/>
ETHNICITY	White/Anglo	<input type="checkbox"/>
	Hispanic/Spanish	<input type="checkbox"/>
	African American/Black	<input type="checkbox"/>
	A.Indian/Eskimo/Aleut/Othr	<input type="checkbox"/>
INSURANCE	Medicaid	<input type="checkbox"/>
	Medicare	<input type="checkbox"/>
	County Hospital <small>(CARELINK, GOLD CARD, NUÉCES AID, etc.)</small>	<input type="checkbox"/>
	Veteran's Insurance	<input type="checkbox"/>
	Private Insurance	<input type="checkbox"/>
	None	<input type="checkbox"/>
LIVING ARRANGEMENTS	Alone	<input type="checkbox"/>
	W/ Spouse	<input type="checkbox"/>
	W/ Family	<input type="checkbox"/>
	W/ Non-Family	<input type="checkbox"/>
	Nursing/Retirement Facility	<input type="checkbox"/>
	Homeless	<input type="checkbox"/>

### MONTHLY INCOME SOURCE(S)

VET, Military, Family: EXEMPT INCOME

COSA CDBG: LIMITED CLIENTELE

SSI / SSDI: \_\_\_\_\_

AFDC/TANF: \_\_\_\_\_

Child Support: \_\_\_\_\_

Family/Friends: \_\_\_\_\_

Wages/Salary: \_\_\_\_\_

Pension/Retirement: \_\_\_\_\_

Other: \_\_\_\_\_

TTL Monthly Income: \_\_\_\_\_

Annual Income: \_\_\_\_\_

**\*\*\*If ZERO income, Narrative *Required* on Income Certification Form\*\*\***

PROJECT MEND STAFF ONLY:

COSA-CDBG   
 Bexar County   
 JEREMIAH   
 Other Area (UT)   
 COASTAL BEND(UT)

ALAMO AREA (UT)   
 Children   
 Alcoa   
 Greehey

Updated: 03/17/2010

**DOCUMENT CHECKLIST:**

**PICTURE ID**

**SOCIAL SECURITY CARD**

**PROOF OF INCOME**

**PRESCRIPTION FROM DOCTOR**

**\$20 PROCESSING FEE**