



**Direct Aid Intake  
Form**

1422 Bragg Boulevard  
Fayetteville, NC 28301  
Phone: (910) 483-7534  
FAX: (910) 483-2157  
Email: information@betterhealthcc.org

Name of Client \_\_\_\_\_  
First MI Last

Address \_\_\_\_\_  
Street Address City Zip Code

Phone Number \_\_\_\_\_ Military Affiliated \_\_\_\_\_

Gender: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Is client on Disability? \_\_\_\_\_ # in Household \_\_\_\_\_

Was patient discharged from hospital or ER within last 7 days? \_\_\_\_\_ # of minors in HH \_\_\_\_\_

Is your family experiencing homelessness? \_\_\_\_\_ Female Head of Household? \_\_\_\_\_

**Household Monthly Income Amount & Source**

Proper documentation must be presented before assistance can be given.

Type	Amount
Wages/Earnings	_____
Food Stamps	_____
Social Security	_____
Disability	_____
Retirement	_____
Alimony/Child Support	_____
Unemployment	_____
Other	_____
<b>Total Monthly Income</b>	_____

**Ethnicity:**

Hispanic \_\_\_\_\_  
Non-Hispanic \_\_\_\_\_  
Hispanic/other \_\_\_\_\_

**Race: Please check one.**

\_\_\_\_\_ Am. Indian/Alaska Native  
\_\_\_\_\_ Asian  
\_\_\_\_\_ Black/African American  
\_\_\_\_\_ Native Hawaiian/Pacific Islander  
\_\_\_\_\_ White  
\_\_\_\_\_ Other Multi-racial

Diagnosis/Reason for visit \_\_\_\_\_ Physician \_\_\_\_\_

Health Insurance \_\_\_\_\_ Medicare or Medicaid \_\_\_\_\_

**Please check off the type of assistance requested:**

\_\_\_\_ Dental extraction    \_\_\_\_ Prescription    \_\_\_\_ Gas voucher for out of town appointments  
\_\_\_\_ Vision    \_\_\_\_ Diabetes education    \_\_\_\_ Diabetic supplies    \_\_\_\_ Incontinent Supplies  
\_\_\_\_ Liquid nutrition    \_\_\_\_ Ostomy supplies    \_\_\_\_ Wound care    \_\_\_\_ Other \_\_\_\_\_

I hereby certify that the information provided is true and correct to the best of my knowledge. Falsification of information can result in loss of services and negative legal consequences. This information will be used solely for purpose of qualifying the above named individual for the Direct Aid Program at Better Health of Cumberland County, Inc.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

For Referring Agency: \_\_\_\_\_  
Agency Name Phone Number



\_\_\_\_\_  
Name of person making referral

\_\_\_\_\_  
Signature of person making referral

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