Central Jersey Family Health Consortium

Central Intake

Community Health Screening

* REQUIRED *

PLEASE PRINT CLEARLY

*Date of Referral ___-___-___

Participant Information

*Last Name _____ *First Name _____ *Date of Birth ___-___-___

*Street Address _____ *City _____

*Zip Code _____ *County _____ Participant ID _____

*Primary Language
(Choose one)
- ○ English
- ○ Spanish
- ○ Other _____

*Race
(Choose one)
- ○ Black
- ○ White
- ○ Asian
- ○ Native American
- ○ Multi-Racial
- ○ Alaskan/Pacific Islander
- ○ Other _____

*Ethnicity Hispanic ○ Yes ○ No

*Health Insurance (Select all that apply)
- ○ Medicaid PE
- ○ Medicare
- ○ Medicaid MC
- ○ Commercial/Private
- ○ NJ Family Care
- ○ Uninsured/Self Pay

Participant Contact Information

*Primary Phone ___-___-___

Alternate Phone ___-___-___

Email Address _____

*Preferred Contact Method
(Choose one)
- ○ Primary Phone
- ○ Email
- ○ Alternate Phone
- ○ Text

*At which phone number can we text you?
- ○ Primary
- ○ None
- ○ Alternate

Household Information

Married? ○ Yes ○ No

*# of Children in the home ___

Date(s) of birth of children needing services	Name of Child	Relationship
1. ___/___/___		
2. ___/___/___		
3. ___/___/___		

Participant Is... *(Choose One)*

○ Preconceptional Woman	○ Pregnant Woman	○ Interconceptional Woman	○ Male
Has no children and has never been pregnant.	*First Time Parent? ○ Yes ○ No *In Prenatal Care? ○ Yes ○ No *Due Date ___-___-___	*Previously pregnant and not currently pregnant. (Does not matter if woman has children.)* *First Time Parent? ○ Yes ○ No	*Are you a Parent? ○ Yes ○ No *First Time Parent? ○ Yes ○ No Does your child live w/ you? ○ Yes ○ No

Reason for Referral - Household Needs

- ___ Primary care for myself
- ___ Primary care for my children
- ___ Prenatal care
- ___ Public benefits
- ___ In-home parent support (home visiting)
- ___ Assistance connecting to services (CHW)
- ___ Group parent support
- ___ Other _____

Referral Agency Information

*Referral Agency Name _____

Name of Person Making the Referral _____ Phone ___-___-___

Email Address _____ Phone Extension _____

Comments

Program Use Only

Date Pregnancy Test Given ___-___-___

Pregnancy Test Positive? ○ Yes ○ No

Outreach Type
- ○ Agency
- ○ Door to Door
- ○ Self
- ○ Event *(Specify)* _____

*Participant Consent

I agree to have the information I provided for this initial referral shared with the Central Intake hub for my county. I agree to be contacted by Central Intake staff, who will further assist with connecting me and/or my family to supportive services.

○ Oral consent given

Signature of Participant

Sign _____ *Print* _____

Participants under the age of 18 understand that it is in their best interest to include a trusted adult in decisions related to health.

Fax: (732) 937-5540

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