For Office Use Only: Client ID# _____

Health District
OF NORTHERN LARIMER COUNTY

Application for Tobacco Treatment Services

Please complete the following information:

Last Name _____ **First Name** _____ **Middle Initial** ____

Residence Address _____ **Apt/Lot #** _____ **City/State/Zip** _____

☐ **I do not have a stable place to live. Please contact me at** ☐ Catholic Charities ☐ Open Door Mission
☐ Murphy Center ☐ Other _____

Mailing Address (if different than above) _____

Email ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Date of Birth _____ Age _____ **Sex** ○ Female ○ Male

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Sometimes the Health District needs to follow-up with clients about the services they received. How would you prefer we contact you? (Mark all that apply.)

- ☐ Cell phone
- ☐ Home phone
- ☐ Work phone
- ☐ Email
- ☐ Regular mail
- ☐ I prefer you don't contact me
- ☐ For simple things, please use text-messaging to my cell phone

In case of an emergency, the Health District should call the following local contact:

Name _____ Relationship _____

Phone _____ or Phone _____

What is your race or ethnicity? (Please check one):

- ○ White
- ○ Hispanic/Latino
- ○ African American/Black
- ○ Asian or Pacific Islander
- ○ American Indian, Eskimo or Aleut

What is the main language you speak? (Please check one):

- ○ English
- ○ Spanish
- ○ Bilingual English/Spanish
- ○ Other _____

Continued on the back

Please complete the following information:

Please circle the highest grade of school you have completed.

0	1 2 3 4 5 6 7 8 9	10 11 12	13 14 15 16	17 18 19 20
None	Grade School	High School/GED	Vocational/Technical/College	Graduate Degree

Are you:

- ○ Employed full time (35 or more hours per week)
- ○ Employed part time (less than 35 hours per week)
- ○ Self-employed
- ○ Retired
- ○ Unemployed

Do you have a regular doctor or health care provider? ○ Yes ○ No

If Yes, doctor's or medical provider's name: _____

Are you a veteran? ○ Yes ○ No If yes, do you use the VA Clinic? ○ Yes ○ No

What is your health insurance program/coverage? (Check all that apply)

- ☐ No health insurance
- ☐ Colorado Indigent Care Program (CICP)
- ☐ Medicaid (Primarily for children and low-income adults) # _____
- ☐ Medicare (Primarily for adults over 65 years old) # _____
- ☐ Private or commercial insurance _____
- ☐ Veteran benefits
- ☐ Other _____

If you live in the Health District and are interested in a sliding fee scale, please fill out the following:

Including you, how many people live in your home? _____

What is your total estimated monthly household income? $ _____

For Staff Use Only: **Level:** ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ Full Pay

How did you hear about us? (Check all that apply.)

- ☐ Bus ad
- ☐ Community presentation
- ☐ *Compass*
- ☐ Counselor
- ☐ Dentist
- ☐ Doctor
- ☐ Family/friend
- ☐ Former client
- ☐ Health fair
- ☐ Internet
  - ☐ Health District website
  - ☐ HealthInfoSource.com
  - ☐ Facebook or other social media
- ☐ Newspaper ad or article
- ☐ Other Health District program
- ☐ Thinking of Quitting card
- ☐ Other _____

I understand and agree that all my information given above is accurate to the best of my knowledge. Providing false information or withholding information may result in denial of services.

_____ _____

Client's Signature **Date**