Part 1. Client Information			
Client Name	First MI Last		
Gender	☐M ☐Transgender M to F ☐F ☐Transgender F to M	**Marital Status Box A**	☐Married (1) ☐Single (2) ☐Divorced (3) ☐Separated (4) ☐Widowed (5)
SSN (Last 4)	____ ____ ____ ____	**Date of Birth**	MM / DD / YYYY
Home Address		**City/State/Zip**	
Mailing Address		**City/State/Zip**	
Phone #		**Email**	

Homeless	**Disability**	**Veteran**	**Pregnant**	**Due Date if Yes**
☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	/ /

Medical Insurance Box B	None☐ (N) ☐Medical Assistance (MA) ☐Private (P) ☐Medicare (MC) ☐PAC (C) ☐VA (V) ☐Other	**Transportation Problem**	☐Frequently ☐Sometimes ☐Never ☐Unknown
Ethnicity Box C	Are you Hispanic/Latino? ☐ Yes (Y) ☐ No (N)	**Race(s) Box D**	☐ White (1) ☐ Black or African-American (2) ☐ Asian (3) ☐ American Indian/Alaska Native (4) ☐ Native Hawaiian/Pacific Islander (5)

Part 2. Household Information

Please complete information for all household members. Use Marital Status, Medical Ins, Ethnicity, and Race codes from Boxes A, B, C, and D above.

Name	First MI Last			Gender	Relationship to You
				☐ M ☐ F ☐ T- M to F ☐ T- F to M	⇩
Marital Status(Box A)	Soc Sec # (Last 4)		Date of Birth	/ /	

Disability	Veteran	Pregnant	Due Date if Yes		Medical Ins.(Box B)	Ethnicity(Box C)	Race(s)(Box D)
☐Y N☐	☐Y N☐	☐Y N☐		/ /			

Name	First MI Last			Gender	Relationship to You
				☐ M ☐ F ☐ T- M to F ☐ T- F to M	⇩
Marital Status(Box A)	Soc Sec # (Last 4)		Date of Birth	/ /	

Disability	Veteran	Pregnant	Due Date if Yes		Medical Ins.(Box B)	Ethnicity(Box C)	Race(s)(Box D)
☐Y N☐	☐Y N☐	☐Y N☐		/ /			

Name	First MI Last			Gender	Relationship to You
				☐ M ☐ F ☐ T- M to F ☐ T- F to M	⇩
Marital Status(Box A)	Soc Sec # (Last 4)		Date of Birth	/ /	

Disability	Veteran	Pregnant	Due Date if Yes		Medical Ins.(Box B)	Ethnicity(Box C)	Race(s)(Box D)
☐Y N☐	☐Y N☐	☐Y N☐		/ /			

Name	First MI Last			Gender	Relationship to You
				☐ M ☐ F ☐ T- M to F ☐ T- F to M	⇩
Marital Status(Box A)	Soc Sec # (Last 4)		Date of Birth	/ /	

Disability	Veteran	Pregnant	Due Date if Yes		Medical Ins.(Box B)	Ethnicity(Box C)	Race(s)(Box D)
☐Y N☐	☐Y N☐	☐Y N☐		/ /			

Part 2. Cont.	Use Marital Status, Medical Ins, Ethnicity, and Race codes from Boxes A, B, C, and D on the other side of the form.

Name	First MI Last	Gender ☐ M ☐ F ☐ T- M to F ☐ T- F to M	Relationship to You ⇩
Marital Status(Box A)	Soc Sec # (Last 4)	Date of Birth / /	
Disability ☐Y NO☐	Veteran ☐Y NO☐	Pregnant ☐Y NO☐	Due Date if Yes / /
Medical Ins.(Box B)	Ethnicity(Box C)	Race(s)(Box D)	

Name	First MI Last	Gender ☐ M ☐ F ☐ T- M to F ☐ T- F to M	Relationship to You ⇩
Marital Status(Box A)	Soc Sec # (Last 4)	Date of Birth / /	
Disability ☐Y NO☐	Veteran ☐Y NO☐	Pregnant ☐Y NO☐	Due Date if Yes / /
Medical Ins.(Box B)	Ethnicity(Box C)	Race(s)(Box D)	

Name	First MI Last	Gender ☐ M ☐ F ☐ T- M to F ☐ T- F to M	Relationship to You ⇩
Marital Status(Box A)	Soc Sec # (Last 4)	Date of Birth / /	
Disability ☐Y NO☐	Veteran ☐Y NO☐	Pregnant ☐Y NO☐	Due Date if Yes / /
Medical Ins.(Box B)	Ethnicity(Box C)	Race(s)(Box D)	

Client Acknowledgement of Data Entry into Community ServicePoint System

The Community ServicePoint System (CSP) is used by provider agencies to record information about clients that they serve. This information helps the agencies to plan for and provide services to clients. This information also can be shared among agencies, if you, the client, agree in order to improve the coordination and delivery of your services.

By signing this document you are:

- Acknowledging that demographic information about you and your family will be entered into the Community ServicePoint (CSP)
- Allowing basic demographic information about you / your family to be viewed by our partner providers. (See List)

This information includes your name and last 4 digits of your social, contact information such as phone number, address, and email address along with, age, race, nationality, disability status, veteran, and medical insurance status. Sharing of this information will allow you to be served by other agencies without repeating basic information about yourself / your family. Other information will not be shared without your written approval. Your approval or disapproval does not affect your eligibility status.

☐ Checking the Box to the left to allows your information to be shared with other agencies.

Check the Right Box to request that information Not Be Shared with Other Agencies: ☐

____
Client's Signature

____
Other Party
(Client is minor or requires guardian)

____
Date Signed

____
Relationship to Client

____
Effective Date

____
End Date