BETTER HEALTH
Better Life. Better Community.

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 Affiliation: Active, Veteran, Dependent or None**

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	_____
Total Monthly Income	_____

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

United Way Community Partner

_____ _____
Name of person making referral Signature of person making referral

Revised 7/2025