



## Direct Aid Intake Form

1422 Bragg Boulevard  
Fayetteville, NC 28301  
Phone: (910) 483-7534  
FAX: (910) 483-2157

Please complete all categories

Date of Application: \_\_\_\_\_

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 \_\_\_\_\_

Female Head of Household? \_\_\_\_\_ Were you or your household affected by Covid-19? \_\_\_\_\_

### 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 \_\_\_\_\_ Physician \_\_\_\_\_

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

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

_____ Dental extraction	_____ Prescription	_____ Transportation	_____ 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



Community Partner

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

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

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