THIS SECTION FOR SBHC OFFICE TO COMPLETE

1. School-Based Health Center: **GATEWAY** **2. Client Identifier:**

School-Based Health Center Enrollment Form

Massachusetts Department of Public Health

3. Today's Date: __ __ / __ __ / __ __ __ __
(Enrollment Date)

4. Name: ______________________________
(First, Last)

5. Date of Birth: __ __ / __ __ / __ __ __ __

6. Gender: ☐ Female ☐ Male ☐ Transgender

7. Zip Code (Primary Address): __ __ __ __ __

8. Are you Spanish/Hispanic/Latino? ☐ Yes ☐ No ☐ Unknown/Not specified

9. What is your ethnicity? (You can specify more than one)

☐ African (Specify) ____________________
☐ African American
☐ American
☐ Asian Indian
☐ Brazilian
☐ Cambodian
☐ Cape Verdean
☐ Caribbean Islander
☐ Chinese
☐ Colombian
☐ Cuban
☐ Dominican
☐ European
☐ Filipino
☐ Guatemalan
☐ Haitian
☐ Honduran
☐ Japanese
☐ Korean
☐ Laotian
☐ Mexican, Mexican American, Chicano
☐ Middle Eastern
☐ Other (Specify) __________________
☐ Portuguese
☐ Puerto Rican
☐ Russian
☐ Salvadoran
☐ Vietnamese
☐ Unknown/ Not specified

10. What is your race? (You can specify more than one)

☐ American Indian/Alaska Native ☐ Black ☐ White ☐ Other (Specify) ____________________
☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Unknown/Not specified

11. In what language do you prefer to discuss health-related concerns? ______________________________

12. In what language do you prefer to read health-related materials? ______________________________

13. Do you have health insurance? ☐ Yes ☐ No ☐ Unknown ☐ No – Health Safety Net/HSN/Free Care

14. If yes, what is the name of your primary insurance?

☐ MassHealth: *Plans may include:*
Boston Medical Center HealthNet Plan
Fallon Community Health Plan
Neighborhood Health Plan
Network Health Plan
Health New England

☐ Children's Medical Security Plan
☐ Aetna
☐ Blue Cross/Blue Shield
☐ Champus Tricare
☐ Cigna
☐ Fallon (Non MassHealth)

☐ Other (Specify)____________________
☐ Harvard Pilgrim
☐ John Hancock
☐ Network Health Plan (Non MassHealth)
☐ United Health NE (Non MassHealth)
☐ Tufts

15. In the last 12 months, did you receive a complete physical exam? ☐ Yes ☐ No ☐ Unknown

16. In the last 12 months, where did you go most often for healthcare?

☐ Office, clinic or community health center ☐ Hospital ER ☐ Other (Specify) ________________________
☐ School-based health center ☐ Didn't go for care ☐ Unknown

17. Do you have dental insurance? ☐ Yes ☐ No ☐ Unknown

18. In the last 12 months, did you receive a comprehensive dental exam? ☐ Yes ☐ No ☐ Unknown

19. Are you a student? ☐ Yes ☐ No

20. If no, please indicate how you became a client of this school clinic. (Choose the one that is most relevant)

☐ Graduate of School ☐ Child of Student ☐ Relative of Student ☐ Community Member ☐ School Staff

21. Do you receive special education services? ☐ Yes ☐ No ☐ Unknown

22. Do you receive free or reduced-cost school lunches? ☐ Yes ☐ No ☐ Unknown

23. Do you have a chronic health condition? ☐ Yes ☐ No ☐ Unknown
(Examples: Asthma, Diabetes, Allergies, Attention Deficit Disorder (ADD/ADHD), Hypertension, Depression, Eczema/Skin Rashes)