Part I: Member Identification and Demographics

Member First Name	Member Last Name	M.I.	Preferred Name	Medicaid ID#	Date of Birth:

Current Residential Address:					
Street:		City and State:		Zip Code:	
Mailing Address (if different from current address):					
Street:		City and State:		Zip Code:	

Best Contact Phone Information:	Number	Can receive texts?	Email Address:	Any friends or family who can help reach you? Yes ☐ No ☐ If yes, please specify:	Contact Name:
	1.	Yes ☐ No ☐			Contact Ph Number:
	2.	Yes ☐ No ☐			Relationship to Member:

If deemed eligible for CIS, anyone the member would like present for the assessment and action planning steps?	Yes ☐ No ☐ If yes, list:	Name:	Name:
		Ph Number:	Ph Number:
		Relationship to Member:	Relationship to Member:

Member QUEST Health Plan: ☐ AlohaCare ☐ HMSA ☐ Kaiser ☐ Ohana ☐ UHC	Is Member in CCS? ☐ Yes ☐ No	Lead Health Plan's Member ID:	Member QUEST ID:

Member HMIS ID: ☐ Unknown ☐ Member not in HMIS	Is the Member a Veteran? ☐ Yes ☐ No	If yes, VA ID: ☐ Unknown	Other Insurance/ID #:

Would the member prefer to receive services from one or more of homeless service providers? ☐ Yes ☐ No If Yes, identify:
Is the member currently received any services related to their homelessness? ☐ Yes ☐ No If Yes, Please Respond:

#	Agency(ies) Providing Services:	Types of Services Being Provided:
1.		
2.		
Other:		

These questions may be directed to the member:

Do you think of yourself as:	Do you think of yourself as:	Preferred Pronoun:
☐ Straight or heterosexual ☐ Queer, pansexual, and/or questioning ☐ Lesbian or gay ☐ Bisexual ☐ Something else, please specify: ☐ Don't know ☐ Decline to answer	☐ Male ☐ Female ☐ Transgender man/trans man/female-to-male (FTM) ☐ Transgender woman/trans woman/male-to-female (MTF) ☐ Genderqueer/gender nonconforming neither exclusively male nor female ☐ Additional gender category (or other); please specify: ☐ Decline to answer	

Part II: Additional Pertinent Information

Is the member currently a threat to self or others?	Yes ☐ No ☐	If yes, Explain:
Is the member in any immediate danger or did the member disclose experiencing violence or abuse by or fear of another party with whom they are in contact?	Yes ☐ No ☐	If yes, Explain:
Does the member have interpretation needs?	Yes ☐ No ☐	If yes, in which language(s) does the member need interpretation services?

Other Pertinent Information:

Part II. Member Eligibility Confirmation and Consent

The member is confirmed to qualify for CIS based on the following criteria:

PART A: HEALTH NEEDS-BASED CRITERIA		
Select		Criteria (At Least One MUST Apply for Member to be Eligible)
☐		**BEHAVIORAL HEALTH NEED**, BASED ON:
	☐	MENTAL HEALTH NEED **and/or**
	☐	SUBSTANCE USE NEED
☐		**COMPLEX PHYSICAL HEALTH NEED**
PART B: HOUSING CRITERIA		
Select		Criteria (At Least One MUST Apply for Member to be Eligible)
☐		**HOMELESSNESS**
	☐	UNSHELTERED
	☐	SHELTERED
☐		**AT RISK OF HOMELESSNESS**
	☐	RISK OF IMMINENT EVICTION
	☐	FREQUENT INSTITUTIONAL STAYS
	☐	*Transitioning out of:* ☐ Nursing Facility/Other LTC ☐ Inpatient psychiatric hospital ☐ Inpatient medical hospital ☐ Correctional program/institution

I, _____ voluntarily agree to enroll in Community Integration Services (CIS).

Member Signature	Member Advocate Signature (if applicable)	Date

I hereby certify that the information contained in this form is true and correct to the best of my knowledge.

Interviewer Signature	Interviewer Name & Title	Date

CIS Services Agency or Health Plan Name (as applicable)	Phone Number & E-mail Address