Glide Harm Reduction Intake

Date:

GENERAL INFORMATION

Last Name:	First Name:	Birth Date:
Street and Apt/Room #:	City:	Zip:
SSN:	If Applicable, projected date of release:	
Email:	Phone: ( )	Ext:

What is the best way to reach you?

Gender ☐Male ☐Female ☐Transgender (FTM) ☐Transgender (MTF) ☐Other

Race ☐White ☐Black ☐Asian/Pacific Islander ☐Hispanic/Latino ☐Native American ☐Multi-Racial/Other_____

Primary Language ☐English ☐Spanish ☐Cantonese/Mandarin ☐Vietnamese ☐Tagalog ☐Arabic ☐Other_____

Current Housing Status ☐SRO ☐Staying with family/friends ☐Rent house/apt ☐Jail ☐Shelter/Mission ☐Street/Outdoors ☐Vehicle ☐Transitional Housing ☐Other: _____

SERVICES

Are you interested in receiving HCV treatment?

☐ Yes (see next question) ☐ No

If interested in treatment, are you willing to take a pill every day?

☐ Yes ☐ No

Are you interested in receiving support in other areas such as:

☐ Drug Treatment

☐ Medication Adherence Support

☐ Insurance/Benefits Navigation

☐ Other_____

NOTES

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