FOR OFFICE USE ONLY

Chart Links MR#___________________

CIVIC Member ID#_________________

DEMOGRAPHIC DATA SHEET

Name: ____ Birthdate: ____________________

Zip Code: ____________________ Date of Service: _________________ Gender: M F

*The United Way of Central Ohio and other funders require us to report certain information about the people that we serve. It is also important to us that our services are provided in a manner which respects each person's cultural background. Therefore we are asking you to provide us with the following information about the person who will be receiving services. When we report this demographic information to United Way or other funders **we will not use your name**. Although we do hope you will provide us with this information, you are certainly not required to do so.*

Please mark the choice which best describes the client's race:

- ❒ White/Caucasian (C)
- ❒ Black or African-American (B)
- ❒ American Indian or Alaskan Native (N)
- ❒ Client does not wish to provide (R)
- ❒ Asian (A)
- ❒ Bi-racial or multiple races (M)
- ❒ Other (O) _____________________

Please mark the choice which best describes the client's ethnicity:

- ❒ No, not of Hispanic, Latino or Spanish origin (N)
- ❒ Yes, of Hispanic, Latino or Spanish origin (Y)

If the client is an immigrant, please provide the country of birth:_______________________________

Household Income:

- ❒ Below $4,999 (A)
- ❒ $5,000 - $9,999 (B)
- ❒ $10,000 - $19,999 (C)
- ❒ $20,000 - $39,999 (D)
- ❒ $40,000 - $59,999 (E)
- ❒ $60,000 - $79,999 (F)
- ❒ $80,000 & above (G)
- ❒ Do not wish to disclose (R)

Number of people who live in the household: ___________

Thank you very much for your assistance in providing us with this information.

Business office use only

Client Name_______________________

❒ 6 years of age or older

SLP/Audiologist_____________________

Detection of Delay/Disorder

Speech/Language

❒ Yes ❒ No

❒ Screened hearing and recommending follow-up

Hearing

❒ Yes ❒ No

❒ Screened speech and recommending follow-up

Referral(s) *(may select all that apply)*

- ❑ Intervention – Speech **DX** __________
- ❑ Intervention - OT
- ❑ Intervention - Audio
- ❑ Physician/Medical Follow-up
- ❑ Help Me Grow *(up to 2 ½ years old)*
- ❑ Public School System *(older than 2 ½)*
- ❑ Parent Education
- ❑ Other ________________________

Verification with Caregiver

- ❑ Yes, appointment made
- ❑ Yes, appointment kept
- ❑ Yes, but did not keep appointment
- ❑ No, on waiting list
- ❑ No, did not make appointment
- ❑ No appointment necessary
- ❑ Client refused to provide information

Attempted contact on 1)____________

Attempted contact on 2)____________

Attempted contact on 3)____________

❑ Unable to contact

Verification entered in CTK db _________________________ (date and initials)

INTERVENTION PROGRAM

Therapy Scheduled to begin: ________________

❑ Started Therapy

Entered in Intervention CTK db _________________________ (date and initials)