WHITMAN-WALKER HEALTH
Community. Caring. Quality.

TransLAW
TRANS LEGAL ADVOCATES OF WASHINGTON

CLINIC DATE: _____

Name and Gender Change Clinic: Intake Form 2015

Preferred Name (name you use):_____ **Preferred Pronoun:**_____

Full LEGAL Name (if different):_____

Address:_____
(Number, Street, Apt./Suite) (City) (State) (County) (Zip)

1st Phone:_____ **Is it ok for WWH/TransLAW to leave voicemail?** □ Yes □ No
2nd Phone:_____ **Is it ok for WWH/TransLAW to leave voicemail?** □ Yes □ No
Email Address:_____ **Prefer contact by:** □ 1st Phone □ 2nd Phone □ Email

Date of Birth:_____ **Age:**_____ **Social Security Number:**_____-_____-_____
City, State, Country of Birth:_____
Are you a U.S. Citizen? □ Yes □ No ****** If NO, then please complete the Immigration Checklist ******
Do you have a Current Government-Issued ID? □ Yes – Which State? _____ □ No

Sex at Birth:	**Current Gender Identity:**	**Sexual Orientation:**
□ Female □ Male □ Intersex	□ Female □ Trans Female/Transwoman/MTF □ Male □ Trans Male/Transman/FTM □ Genderqueer □ Other:_____	□ Gay/Lesbian □ Bisexual □ None of □ Straight these

Race:	**HIV Status:**	**Are you a Military Veteran?**
□ Asian □ Multiracial/Other □ Black □ Native American □ Hispanic □ White	□ Positive □ Negative or Unsure	□ Yes □ No

Housing Stability:	**Are you legally married?** □ Yes – Which State? _____ □ No **Do you share your home with a life partner (i.e. not a roommate)?** □ Yes □ No **How many individuals (including you) live in your household who are under 18 years old?** _____ **over 18 years old?** _____
□ Homeless/in shelter □ Residential treatment facility / transitional housing program □ Staying with family member/friend □ Renting a room/apt/house □ Own a home □ Other_____	

Insurance Coverage:	**Do you use any of these WWH programs? Please include your provider's name.**
□ Medicaid □ Private insurance (thru employer or DC Exchange) □ DC Alliance □ Medicare □ None □ Other: _____	□ Pharmacy □ Dental: _____ □ Medical (Primary/Hormones/HIV/other): _____ □ Medical Adherence/Case Mgmt:_____ □ Mental / Behavioral Health:_____ □ Other Services:_____ □ None, but I would like to learn more about these services □ None, and I am not interested in being a WWH patient

Total Monthly Income (*if any*):
□ SSDI/SSI $_____ □ Work $_____ □ Unemployment Benefits $_____ □ Other _____ $_____

CLIENT SIGNATURE: _____ **DATE:** _____