

# FAMILY PLANNING CLINIC ADMISSION SHEET COFFEY COUNTY HEALTH DEPARTMENT

**PLEASE COMPLETE THE FOLLOWING INFORMATION, WHICH IS REQUIRED FOR PROGRAMS RECEIVING FEDERAL FUNDS.**

NAME: _____	SOC. SEC.# _____
ADDRESS: _____	CITY: _____ ZIP: _____
DATE OF BIRTH: _____	PHONE NUMBER: _____
May we contact you by mail? <input type="checkbox"/> Yes <input type="checkbox"/> No	May we contact you by phone? <input type="checkbox"/> Yes <input type="checkbox"/> No
If no, how may we best contact you? _____	
PRIMARY DR. _____	
EMERGENCY CONTACT – NAME _____	PHONE _____

Sex:  Male  Female

Hispanic/Latino Origin:  Yes  No

(Mark all that apply) Race:

White  Black/African American  American Indian/Alaska Native  Asian  Native Hawaiian/Pacific Islander  Unknown/Not Reported

**PRIMARY HEALTH COVERAGE:**  \*MEDICAID  NO COVERAGE  HEALTHWAVE

\*PRIVATE INSURANCE \_\_\_\_\_  OTHER PUBLIC INSURANCE \_\_\_\_\_  UNKNOWN

\*The Coffey County Health Department can bill Medicaid, Healthwave and Blue Cross/Blue Shield. For other insurance companies, the Client will be given a receipt upon full payment indicating the services rendered.

**GROSS HOUSEHOLD \*INCOME IS \$ \_\_\_\_\_ WEEKLY/ MONTHLY/ YEARLY**

**\*1 INCOME OF ALL ADULTS SHALL INCLUDE, BUT IS NOT LIMITED TO: WAGES, SALARY, COMMISSIONS, UNEMPLOYMENT, CHILD SUPPORT, SRS CASH ASSISTANCE, ALIMONY, AND SCHOOL GRANTS OR SCHOLARSHIPS.**

NUMBER IN THE HOUSEHOLD IS \_\_\_\_\_ (Individuals, related or non-related, living together as one economic unit)

***Voluntary DONATIONS are accepted AND appreciated.***

\_\_\_ I HAVE A MEDICAL CARD FROM SRS. I REALIZE I MUST PRESENT MY CARD IN ORDER TO COVER MY CHARGES. AUTHORIZATION IS GRANTED TO RELEASE THE INFORMATION NECESSARY FOR MEDICAID REIMBURSEMENT.

**PLEASE READ THE FOLLOWING STATEMENT AND SIGN:**

I declare that the statements made in this questionnaire have been made by me and filled out to the best of my knowledge and belief and true, accurate and complete. I understand that I am responsible for payment if I have no insurance or insurance other than Blue Cross/Blue Shield.

I give Coffey County Health Department permission to bill Blue Cross/Blue Shield.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

FOR STAFF ONLY: Annual Income Assessment: \_\_\_\_\_ Level of Discount: \_\_\_\_\_  
English as Primary Language?  Yes  No

\_\_\_\_\_  
(Signature of Staff)

\_\_\_\_\_  
(Date)