WAYNE MEMORIAL COMMUNITY HEALTH CENTERS

We are asking for your help in completing the information on this form. We are collecting this information for governmental reporting purposes. Your help in obtaining this information is greatly appreciated. Your name will not be reported to the government, just the statistical data collected.

Patient Name:_____ DOB _____
PLEASE PRINT YOUR NAME

What is your primary language?
- □ Non-English
- □ Deaf/Sign Language
- □ Interpreter Required

Race:
- □ Asian
- □ Native Hawaiian
- □ Other Pacific Islander
- □ Black/African American
- □ American Indian/Alaskan Native
- □ White/Caucasian
- □ Multiple Race

Ethnicity:
Hispanic or Latino □ yes □ no

Insurance:
- □ Chip
  - □ First Priority
  - □ Geisinger
  - □ Medicaid
- □ Adult Basic
- □ Medicare
- □ Blue Shield
- □ Medical Assistance
- □ Other _____
- □ Self pay

Please check any of the following that apply:

Are you a veteran of the armed services? □ Yes □ No
Migrant Agricultural Worker □ Yes □ No
Seasonal Agricultural Worker □ Yes □ No

Homeless□ Yes □ No (Definition of a homeless person- person who lack housing. This includes persons living with friends and relatives.)

Please define type of Homeless
□ Shelter □ Transitional □ Doubling up □ Street □ Other □Unknown

Tobacco Use □ Yes □ No
□current □Former

Income Range: (Total Family Income)
If you do not wish to report your family income, please mark N/A (not applicable). Thank you.

- □ **patient did not disclose**
- □ $0-$10,999
- □ $11,000-$20, 999
- □ $21,000-$30, 999
- □ $31,000-$40, 999
- □ $41,000-$50, 999
- □ $51,000-$60, 999
- □ $61,000-$70, 999
- □ $71,000-$80, 999
- □ $81,000-$90, 999
- □ $91,000-$100, 999
- □ $101,000 and above

Are you a dependent □ yes □ no
Family Size: _____
(Number of dependents, including yourself and spouse)

Reduced Fees:
□ Yes, I would like to be contacted about the sliding fee program.
□ No, I would not like to be contacted about the sliding fee program.