WAYNE MEMORIAL COMMUNITY HEALTH CENTERS
A Clinical Affiliate of Wayne Memorial Health System, Inc.

Patient Name: _____ Date of Birth: _____

Acknowledgment of Receipt of Patient-Centered Medical Home Information (PCMH)

Wayne Memorial Community Health Centers, a Federally Qualified Health Center (FQHC) and a clinical affiliate of Wayne Memorial Health System, is a Patient Center Medical Home recognized through National Committee for Quality Assurance for its primary care practices.

My signature below constitutes my acknowledgment that I have been provided with a copy of a description, the responsibilities and standards required to achieve and maintain designation as a PCMH.

I understand it is my responsibility to provide a complete medical history and information about care obtained outside the practice upon receiving care through Wayne Memorial Community Health Centers.

_____ _____

Signature of Patient or Legal Representative Date

If signed by legal representative; relationship to patient: _____