

Church Health Services, Inc.

308 Oneida Street
Beaver Dam, WI 53916

Phone: (920) 887-1766

Fax: (920) 887-2322

Website: www.churchclinic.org

Patient Application

Last Name _____ First Name _____ MI _____

Address _____

(Street) _____ (City) _____ (State) _____ (Zip) _____

Home Phone _____ Work Phone _____ SS# _____

Date of Birth _____ Sex _____ Marital Status (Circle) M S W D

Race (Circle) White Black Hispanic American Indian Asian Other

Student? No ___ Yes ___ Where? _____

Parent's Name (If under 18 years of age) _____

1. Do you have a Physician? No ___ Yes ___ If yes, MD name _____

2. Where do you usually go for medical care? _____

3. What are your current health concerns? _____

4. How did you hear about CHS? _____

5. Have you had services through the county in the past? _____

Household Information (List by name, age, relationship)

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Do you have any form of Health Insurance? Yes No

(If Yes, Please check appropriate box)

Medical Assistance Worker's Compensation

Medicare Veterans

Private Policy General Relief

HMO Other (List) _____

List Monthly Household Income (Check box and indicate amount)

Veterans _____ Worker's Comp _____ Gross Wages _____

Pension _____ Social Security _____ SSI/SSD _____

Unemployment _____ Sick Pay _____ Child Support _____

Self-Employment _____ Other _____

Employer/Phone No. _____

Assets (Check box and indicate amount)

Savings _____ IRA _____

Checking Account _____ Stocks/Bonds _____

Non-Homestead Property _____ Other (List) _____

Own your home _____ Automobile (model/year) _____

Expenses

Home/Apartment Payment or Rent _____ Car Payment _____
Other Loans _____ Utilities _____
Unusual Expenses (other medical expenses, child support, credit cards) _____

What types of assistance have you applied for/received in the past?

- | | | |
|--|--|---|
| <input type="checkbox"/> W2 | <input type="checkbox"/> SSI/SSDI | <input type="checkbox"/> Subsidized Housing |
| <input type="checkbox"/> Food Pantry | <input type="checkbox"/> Medical Assistance | <input type="checkbox"/> St. Vincent |
| <input type="checkbox"/> Child Care | <input type="checkbox"/> Energy Assistance | <input type="checkbox"/> Food Stamps |
| <input type="checkbox"/> WIC | <input type="checkbox"/> Salvation Army | <input type="checkbox"/> School Lunch Program |
| <input type="checkbox"/> Renewal Unlimited | <input type="checkbox"/> Wis. Community Action | |

Are you still receiving assistance from one of the above agencies?

Please check one that applies Yes No

Release of Information

I, _____, authorize Church Health Services to obtain any financial information held by the Social Security Administration, County Social Services, lending institutions, or insurance companies on myself, for the purposes of determining eligibility for Church Health Services. This authorization will remain valid for a period of one year from my dated signature or may be revoked by myself at any time, (except to the extent that the Clinic has already acted in reliance on it).

PENALTY WARNING – DO NOT MISREPRESENT OR WITHHOLD FACTS

I understand that if I or any member of my household intentionally misrepresents or withholds facts for the purpose of obtaining services from Church Health Services can be found guilty of a violation of fraud. The individual will be expected to pay for services provided through fraudulent misrepresentation of facts.

IT IS YOUR RESPONSIBILITY TO REPORT ANY CHANGE IN YOUR FINANCIAL OR INSURANCE STATUS TO CHURCH HEALTH SERVICES IMMEDIATELY.

Applicant's Signature _____ Date _____
(Signature of parent or guardian if under 18)

Clinic Representative _____ Date _____

PLEASE RETURN COMPLETED FORM WITH A COPY OF MOST RECENT PAY STUB OF ONE MONTH'S INCOME AND MOST RECENT INCOME TAX FORM FILED.