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? ☐ Yes ☐ No May we contact you by phone? ☐ Yes ☐ No Text: ☐
If no, how may we best contact you? _____
Email Address_____
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: ☐ ***KANCARE(Amerigroup, Sunflower, UnitedHealth)** ☐ **NO COVERAGE**
☐ ***BLUE CROSS/BLUE SHIELD** ☐ ***PREFERRED HEALTH** _____ ☐ **OTHER PUBLIC INSURANCE**
☐ **UNKNOWN**
***The Coffey County Health Department can bill Medicaid, Preferred Health 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.

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, or KanCare. I give Coffey County Health Department permission to bill Blue Cross/Blue Shield, and KanCare and release necessary information for reimbursement. I acknowledge that I have reviewed a copy of CCHD's Notice of Privacy Practices with effective date of April 14, 2003.

Signed: _____ **Date:** _____

FOR STAFF ONLY: Annual Income Assessment: _____ **Level of Discount:** _____
English as Primary Language? ☐ **Yes** ☐ **No**

_____ _____
(Signature of Staff) **(Date)**

[1] J:FAMILY PLANNING:FPADMISSION REVISED 12/10/2013