



FOR OFFICE STAFF ONLY	
PATIENT NUMBER	_____
DATE	_____ CLERK _____
MEDICAID	_____

**SAGINAW COUNTY DEPARTMENT OF PUBLIC HEALTH
PERSONAL AND PREVENTIVE SERVICES
FAMILY PLANNING CLIENT ENROLLMENT FORM**

FIRST NAME: _____ MIDDLE: _____ LAST: _____

MAIDEN NAME (IF DIFFERENT THAN ABOVE): _____

BIRTH DATE (MM/DD/YYYY): _____

SEX (CIRCLE ONE): FEMALE MALE

RACE (CHECK ALL THAT APPLY):

- AMERICAN INDIAN/ALASKAN ASIAN AFRICAN AMERICAN
 HAWAIIAN/PACIFIC ISLANDER WHITE

ETHNICITY (CHECK ONE ONLY):

- HISPANIC NON-HISPANIC UNKNOWN

MARITAL STATUS:

- NEVER MARRIED MARRIED DIVORCED SEPARATED WIDOWED

CONTACT INFORMATION

HOME ADDRESS

STREET: _____ APT: _____

CITY: _____ STATE: _____ ZIP CODE: _____

COUNTY OF RESIDENCE: _____ TOWNSHIP: _____

MAY WE SEND MAIL TO THE ABOVE ADDRESS? YES NO

IF NO, PLEASE PROVIDE AN ADDRESS WHERE WE MAY CONTACT YOU BY MAIL

STREET: _____ APT: _____

CITY: _____ STATE: _____ ZIP CODE: _____

COUNTY OF RESIDENCE: _____ TOWNSHIP: _____

HOME PHONE: () _____ MAY WE CONTACT YOU AT THIS NUMBER? YES NO

CELL PHONE: () _____ MAY WE CONTACT YOU AT THIS NUMBER? YES NO

WORK PHONE: () _____ MAY WE CONTACT YOU AT THIS NUMBER? YES NO

IF NO TO ALL ABOVE NUMBERS, PLEASE PROVIDE A PHONE NUMBER WHERE WE MAY REACH YOU

CONTACT NUMBER: () _____

EDUCATION

HIGHEST GRADE COMPLETED: _____

COLLEGE (NUMBER OF YEARS COMPLETED): _____



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CLIENT FINANCIAL DATA

EMPLOYMENT STATUS (PLEASE CHECK ALL THAT APPLY):

- | | | |
|---|---|--|
| <input type="checkbox"/> DISABLED | <input type="checkbox"/> EMPLOYED FULL-TIME | <input type="checkbox"/> EMPLOYED PART-TIME |
| <input type="checkbox"/> HOMEMAKER | <input type="checkbox"/> SEEKING WORK | <input type="checkbox"/> NOT SEEKING WORK |
| <input type="checkbox"/> STUDENT | <input type="checkbox"/> RETIRED | <input type="checkbox"/> SEASONAL EMPLOYMENT |
| <input type="checkbox"/> OTHER (PROVIDE MEANS OF SUPPORT HERE): _____ | | |

YOUR PERSONAL INCOME (BEFORE DEDUCTIONS):

HOURLY WAGE \$ _____ NUMBER OF HOURS WORKED PER WEEK: _____

HOW OFTEN ARE YOU PAID? (CHECK ONE) WEEKLY BI-WEEKLY MONTHLY OTHER

SPOUSE'S INCOME IF APPLICABLE (BEFORE DEDUCTIONS):

HOURLY WAGE \$ _____ NUMBER OF HOURS WORKED PER WEEK: _____

HOW OFTEN ARE YOU PAID? (CHECK ONE) WEEKLY BI-WEEKLY MONTHLY OTHER

OTHER SOURCES OF INCOME (CHECK ALL THAT APPLY AND LIST AMOUNT RECEIVED):

- | | | |
|---|---|---|
| <input type="checkbox"/> WAGE SALARY \$ _____ | <input type="checkbox"/> SOCIAL SECURITY \$ _____ | <input type="checkbox"/> RENTAL INCOME \$ _____ |
| <input type="checkbox"/> GRANT TUITION \$ _____ | <input type="checkbox"/> PENSION \$ _____ | <input type="checkbox"/> SSI \$ _____ |
| <input type="checkbox"/> PARENT SUPPORT \$ _____ | | |
| <input type="checkbox"/> PRIVATE GOVERNMENTAL/MILITARY \$ _____ | | |
| <input type="checkbox"/> SELF-EMPLOYMENT (FARM) \$ _____ | <input type="checkbox"/> SELF-EMPLOYMENT (NONFARM) \$ _____ | |
| <input type="checkbox"/> PUBLE ASSISTANCE/WELFARE/ADC \$ _____ | | |
| <input type="checkbox"/> INTEREST/DIVIDENDS/ROYALTIES \$ _____ | | |

TOTAL HOUSEHOLD INCOME : _____ **# OF PEOPLE SUPPORTED BY THIS INCOME:** _____

(Include parent/guardian income if client is under 18 years of age and parent is aware of the visit)

INSURANCE INFORMATION

- | | |
|---|---|
| <input type="checkbox"/> PUBLIC INSURANCE (MEDICAID, GA, MEDICARE) | <input type="checkbox"/> UNKNOWN/NOT REPORTED |
| <input type="checkbox"/> UNINSURED (NO PUBLIC OR PRIVATE INSURANCE) | |
| <input type="checkbox"/> PRIVATE INSURANCE (HMO, I.E., BLUE CARE, HEALTHPLUS, BCBS, ETC.) | |

SUBSCRIBER'S NAME (FIRST/LAST): _____

SUBSCRIBERS; DATE OF BIRTH (MM/DD/YYYY): _____