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NCH

**Initial Screening Form** **Requalification**

## Name: First:       M.I.:       Last:

**Sex**: **M**:  **F**: **Birth Date**:      **Medicaid #:**

**Ethnicity:** Hispanic/ Latino  Not Hispanic/ Latino  Declined

## Race: American Indian/ Alaska Native Asian Black/ African American Caucasian/ White

Native Hawaiian/ Other Pacific Islander Multiracial  Declined

## Address:      Apt.:

## City:      State: IL Zip:

**Phone Number:** **Home** :(     )       **Cell** :(     )

Receiving General Assistance? Yes: No:  Do you have dental insurance? Yes:  No:

PROVIDE INFO BELOW FOR OTHER FAMILY MEMBERS APPLYING TO USE MDC SERVICES

**Spouses Name**:       **Birth Date**:       **Medicaid #:**

**Sex: M**:  F:  **Race:****Ethnicity**:       (see categories above)

Name:       Birthday:       Gender:       ID#:

Name:       Birthday:       Gender:       ID#:

Name:       Birthday:       Gender:       ID#:

###### 

###### **\*\*PLEASE SEND COPY OF MEDICAID CARD\*\***

Do you need an interpreter? No:  Yes:  If yes, what language:

###### Do you require wheelchair access? Yes: No:

Do you have special needs? Yes:  No:  If Yes, explain:

Proof of address: Yes:No:  Gross monthly income $:

I understand that my immigration/citizenship status in no way affects my ability to receive services from the Northwest Community Healthcare Mobile Dental Clinic.

Are you a U.S. citizen or legal permanent resident? Yes:  No:

**I certify that all statements stated above are true and correct to the best of my knowledge.**

Signature: Date:

Authorizing Agent: Date:

3/2019