#

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