GATEWAY COMMUNITY HEALTH CENTER, INC.

HEAD OF HOUSEHOLD INFORMATION/INFORMACION DEL JEFE DE FAMILIA

Name/Nombre________________________________ **DOB/Fecha de Nacimiento**____/____/____ **SS#**______/______/______
Last/Apellido **First/Nombre** **Initial/Inicial** **Seguro Social**

Address/Domicilio______________________________ **P.O. Box #**____________ **Rent/Renta**_____ **Own/Propiedad**_____

City/Ciudad________ **State/Estado**____ **Zip/C. Postal**_____ **Phone #/Teléfono**__________ **Emergency#/Emergencia**________

Gender/Sexo: M__ F__ **Marital Status/Estado Civil:**Single/Soltero____ Married/Casado_____ Divorced/Divorciado_____

Language Preferred: English___ Spanish___ **Race/Raza:** White/Blanco____ Hispanic/Hispano____ American Indian/Indio

Idioma de Preferencia: Inglés___ Español___ Americano___ Asian/Asiático____ Black/Negro____ Other/Otro___

IMMEDIATE FAMILY MEMBERS/MIEMBROS DE FAMILIA INMEDIATA

Name Nombre Nombre	Last Apellido	First Nombre	Relation to head of household Relacion con el jefe de familia	Sex Sexo (M/F)	Social Security # Numero Social	Date of Birth Fecha de Nacimiento

FOR OFFICE USE ONLY

Name____________ MF#____________ UHI/MIG.____________ Update____________

INSURANCE INFORMATION

Do you have private insurance? Yes___ No___ If yes, please fill out the following information. Medical ___Dental___Rx___
Individual___Family___

Insured Name______________________________ Employer______________________________

Insurance Company______________________________ Is this a group policy? Yes____ No____

Policy Number______________________________ Group Number______________________________

Do you have Medicare? Yes___ No___ ID number______________________________

Do you have Medicaid? Yes___ No___ ID number______________________________

I certify that the information above mentioned is true and correct.
Yo aseguro que la información anteriormente citada es cierta y correcta.

I hereby release insurance information and authorize payment directly to Gateway Community Health Center, Inc. - P.O. Box 3397, Laredo, Tx. 78044 other wise payable to me but not to exceed the charge as stated on the insurance claim form. Yo por este medio doy información de aseguranza médica y autorización de pago directo a Gateway Community Health Center, Inc. El pago debe ser el asignado a mí, y que no exceda la cantidad declarada en el cobro a la aseguranza médica.

HEAD OF HOUSEHOLD/JEFE DE FAMILIA______________________________ **DATE/FECHA**________

Rev. 1/98 Win.C:Reg.

FOR OFFICE USE ONLY

INCOME VERIFICATION

___Income Tax ___Check Stubs ___Other____________ ___Seasonal ___Migrant ___UHI

(1) Verbal Declaration
(2) Employer Letter
(3) School Grant/Scholarship
(4) T.E.C. Benefits
(5) Social Security/Retirement
(6) AFDC Income
(7) Alimony
(8) General Assistance
(9) Stipends
(10) Child Support
(11) Workman Compensation

Office Notes:____

____

Monthly Income $____________ Sliding Fee Scale____________ Federal Poverty Level________%

Family Size #________________ Gross Annual $______________ Class or Payment Code________

RESIDENCE VERIFICATION

Rent Receipt No._______Utility Bill Acct.______

Water___ Gas___ Electricity___ Phone___

Rent Receipt No./Includes utilities_____________

Share Home: Head of Household name:__________

____

Residence Verification Forms:_______________

PUBLIC ASSISTANCE RECIPIENTS

Medicare____ Medicaid____ Food Stamps____

Homeless____ General Assistance____

Other______________________________________

This document can be used to prove that they live in the country.

REMARKS:____

____

____

____

____

____

____

____

____