KCHC
KENOSHA COMMUNITY HEALTH CENTER, INC.

Medical: 4536 22nd Avenue Kenosha, WI 53140
Phone: 262-656-0044 Fax: 262-653-2218

Dental: 6226 14th Avenue Kenosha, WI 53143
Phone: 262-656-0044 Fax: 262-925-1680

Date: _____

PATIENT INFORMATION

Last Name First Name Middle Initial

Date of Birth Social Security Number Gender: □ Male □Female

Home Address Apt # City State Zip Code

Home Phone Work Phone Other Phone □Cell □Pager □Fax

Email Address Pharmacy

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name First Name Relationship to Patient

Address Apt # City State Zip Code

Home Phone Work Phone Other Phone

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient □Self □Spouse □Parent □Other

Last Name First Name

Date of Birth Social Security Number Gender: □ Male □Female

Home Address Apt # City State Zip Code

Home Phone Work Phone Other Phone □Cell □Pager □Fax

Employer Employer Phone

The U. S. Health Resources and Services Administration requests the following information: *(optional)*

Race: □Black/African American □American Indian/ Alaskan Native □ Asian □ Native Hawaiian □ Other Pacific Islander □White

Ethnicity: Hispanic/Latino □ YES □ NO **Language best served:**

Homeless: □YES □NO **Veteran**: □YES □NO **Agricultural Worker:** □YES □NO

Number of Household Members: **Total Gross Household Income:** □ Weekly □ Annual □ Monthly

HOUSEHOLD ASSESSMENT

Patient Name: _____ Date: _____

*Please attach copies of: last year's income tax return; paycheck stubs from last two pay periods; last month's unemployment checks; proof of other household income (social security, SSI, child support. alimony, pension, veterans benefits, workers' compensation, public assistance and/or unemployment benefits for all household members). If you are self employed, please submit your most recent year's tax return. Please note: failure to provide complete documentation will result in sliding fee not being applied and patient will be responsible for all charges.

Are you or any member of your household self-employed? ☐ YES ☐ NO

If yes, please specify type of business and gross income ***AND*** attach a copy of last year's 1040 Tax Return:

Business: _____ Income: _____

List ALL household members and/or dependents (INCLUDING YOU), their ages, and income:

NAME	DOB	EMPLOYED YES	EMPLOYED NO	GROSS INCOME	PER WEEK MONTH OR YEAR

PLEASE LIST OTHER SOURCES OF INCOME:

SOURCE	YES	NO	AMOUNT	PER WEEK, MNTH OR YR
Unemployment Compensation				
Social Security				
Disability Benefits				
Worker's Compensation				
Veterans Benefits				
Alimony				
Child Support				
Other: Pension, Interest, Estate/Trusts etc.				

I AGREE THAT THE ABOVE INFORMATION IS CORRECT AND ALL SOURCES OF INCOME HAVE BEEN REPORTED. I WILL REPORT ANY INCOME CHANGES AND WILL RE-APPLY EVERY SIX MONTHS EVEN IF NO CHANGES OCCUR. FAILURE TO MEET THESE CONDITIONS MAY DISQUALIFY ME FROM FUTURE KCHC FEE DISCOUNTS.

Signed: _____ Date: _____