PBCHD REGISTRATION/ELIGIBILITY FORM

CLIENT INFORMATION

Please Print Clearly

For Financial information only, not official medical record. To be filed **under** eligibility.

First Name	**Middle**	**Last Name**	**Suffix (Jr, II)**

Date of Birth Month Day Year	**Sex** (√): ☐ Male ☐ Female ☐ Transgender	**SS#** - -

Marital Status (√): ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race (√): ☐ White ☐ Black/African American ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Other (Specify)

Language (√): ☐ English ☐ Spanish ☐ Creole ☐ Other (Specify):

Hispanic? ☐ **Yes** ☐ **No**

Country of Birth (√): ☐ USA ☐ Other (Specify):

HCH PROGRAM (√)? ☐ **Yes** ☐ **No**

Address where you live	Apt #
City	Zip Code:
Address where you receive mail (If different from where you live)	Apt #
City	Zip Code:

Telephone #	**Telephone Type** (√): ❑ Cell ❑ Home ❑ Work ❑ Fax ❑ Other

Do you or someone in your household work in farming (including preparing, processing or transporting of product) but **travel for work** during the farming season (Migrant)? ☐ Yes ☐ No

Do you or someone in your household **live in the area** and work in farming (including preparing, processing or transporting of product) all or part of the year (Seasonal)? ☐ Yes ☐ No

Are you a Veteran? ☐ **Yes** ☐ **No**

Were you a single birth? ☐ Yes ☐ No

If NO**, are you a:** ☐ **Twin** ☐ **Triplets** ☐ **Quints or More?**

Were you born ☐ First ☐ Second ☐ Third ☐ Fourth or more?

Are you 18 yrs or older? ☐ Yes ☐ No

If **YES**, what is your Highest Level of Education?

EMERGENCY CONTACT

Name: ____________________ Relationship ____________________

Telephone #: Phone Type (√): ☐ Cell ☐ Home ☐ Work ☐ Fax ☐ Other

Form#155 HMS-PBCHD Rev 10/22/10

Over

INSURANCE TYPE (√)

❑ Health Care District ❑ Healthy Palm Beaches ❑ Medicaid ❑ Medicare ❑ None ❑ Other Specify:

Policy # *Name of Policy Holder: Date of Birth:

PAYOR INFORMATION – Is the Head of Household responsible for paying the bills? ☐ Yes ☐ No If **NO**, complete the information below:

Name: Date of Birth:

Social Security # Address:

Telephone # Telephone Type (√): ❑ Cell ❑ Home ❑ Work ❑ Fax ❑ Other

HOUSEHOLD FINANCIAL INFORMATION

***List the Head of Household first**, then the name of each person in the household
Examples of Income Types: Social Security/Wages/AFDC/Child Support/Unemployment/Workers Compensation/Self-employment Income/Alimony

First Name	MI	Last Name	Relationship to Head of Household	DOB (MM/DD/YY)	Sex	Social Security Number	Race	Employer's Name	Monthly Gross Income	Type Of Income	Child Care Expense (Monthly)
			Head of Household		❑ M ❑ F				$		$
					❑ M ❑ F				$		$
					❑ M ❑ F				$		$
					❑ M ❑ F				$		$
					❑ M ❑ F				$		$
					❑ M ❑ F				$		$

Other Needed Information:

Are you making any payments for child support? ❑ Yes ❑ No If yes, how much is paid each month? $_______________

Are you or any of the family members pregnant? ❑ Yes ❑ No If Yes, Who Due Date: # Babies Due #_____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I GIVE MY CONSENT TO THE PALM BEACH COUNTY HEALTH DEPARTMENT, TO VERIFY THE INFORMATION PROVIDED.

Client/Parent/Guardian Signature:

OFFICIAL USE ONLY Facility: ❑ Belle Glade ❑ Delray ❑ Jupiter ❑ Lantana/LW ❑ Centering Program ❑ Pahokee ❑ Riviera ❑ West Palm Beach

Registered by: **Date:**

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