Family Planning Clinic Intake Form

PLACE LABEL HERE

Information disclosed below allows the SNHD to determine needs/resources for you and the health needs of our community. All information is confidential.

For minors: You can receive services here without parents' permission

How did you hear about us: ☐ **Current Patient** ☐ **Friend/Relative** ☐ **Online** ☐ **DMV** ☐ **Health Fair** ☐ **Referral**

☐ **Teen Pregnancy Project** ☐ **Facebook** ☐ **Twitter** ☐ **SNHD Website** ☐ **Health Fair** ☐ **Other** _____

Would you like assistance locating resources (for example, Medicaid, dental care, food assistance)? ☐ Yes ☐ No

IF YES, explain:

Language most comfortable speaking: _____Do you need an interpreter? ☐ Yes ☐ No

Hearing impaired or need sign language interpreter services? ☐ Yes ☐ No

WE CARE ABOUT YOUR PRIVACY.

We offer confidential services to all our clients. This means we will not release information about your visit to a friend, parent, guardian or relative without your permission.

I ACKNOWLEDGE THAT I HAVE RECEIVED THE "NOTICE OF PRIVACY PRACTICE." _____ (Initial)

INCOME INFORMATION

Our services are based on a sliding fee scale that provides you with a discount. In order for us to give you the best possible discount, it is required that you provide us with proof of income for your household

What is **your** weekly **income before taxes**? Hourly rate of pay _____ Number of hours you work per week _____	
What is your partner/spouse's weekly income **before taxes**? Hourly rate of pay _____ Number of hours you work per week _____	
Any other income to report? (Tips, SSI, etc.) ☐ Yes ☐ No (List type and amount)	
If you live with **and/or** are supported by your parents and they are aware of your visit, what is their weekly income **before taxes**?	
If you have do not have income, please explain how your basic needs are paid for:	
Amount of total weekly income?	
How many people are supported by this income?	

Office Use Only

Sliding fee category: ____

Reviewed by: _____

Referred for Hardship:

Date: _____

Initials: _____

Ref. to EW re services:

Date: _____

Initials: _____

For emergency only: (an emergency would be heavy bleeding, passing out, accident or needing to be taken to a hospital?

Emergency Contact Name: _____ Relationship: _____ Phone Number: _____

I answered all the questions correctly to the best of my knowledge.

_____ _____

Client Signature **Date**