



Community Health Services of Union County, Inc. Free Clinic Screening Form

I WAS REFERRED HERE BY _____

Name: _____ Date of Birth _____

Mailing Address: _____ Zip Code: _____

County: ___Anson ___Union counties in NC or ___Chesterfield ___Lancaster counties in SC

Email address _____

Phone: (H) _____ (C) _____ Gender: Male Female

Employer Name: _____ Retired ___ Unemployed ___ Disabled ___ Number in household: _____

Race: Asian Black/Afr. Amer. Hispanic/Latino Multi-Racial Native American White Other

Income: \$0 to \$9,999 \$25,000 to \$34,999 \$75,000 to \$99,999 \$150,000 to \$199,999
 \$10,000 to \$14,999 \$35,000 to \$49,999 \$100,000 to 149,999 \$200,000 or more
 \$15,000 to \$24,999 \$50,000 to \$74,999 Letter of Support

Health Insurance Coverage (please check all that apply):

Medicare Medicare Supplement Medicaid Private Insurance
 NC Health Choice None

Have you been hospitalized in the last 90 days?

Yes _____ No _____ Date of Hospitalization _____

The last time I saw a Doctor was _____. I certify that I am not now under the care of a Primary Health Care Provider.

Signature _____ Date _____

AUTHORIZATION FOR COMMUNITY HEALTH SERVICES TO RELEASE INFORMATION

TO WHOM IT MAY CONCERN:

This is to authorize Community Health Services, its affiliates, agents, and employees to release any and all records, documents, information, or opinions which may be requested regarding my medical and/or financial condition to any person, firm, agency, or organization as to which such information appears to Community Health Services to be reasonable or necessary to enable myself and/or my family to obtain medical, financial, and/or rehabilitative assistance.

Signature _____ Date _____