Waupaca County Dept of Health & Human Services
Family Planning/Healthy Connections

CLIENT INFORMATION **Lytec #** _____

Client _____ Date _____ /_____ /_____
First Middle Last

☐ Male ☐ Female – maiden name _____ County _____

Address _____ **College Student** ☐ Yes ☐ No

City _____ ____ Zip _____ Soc. Sec. # ____-____-_____

Phone: Home ____-_____-_____ Cell ____-_____-_____ Work ____-_____-_____

DOB _____ /_____ /_____ Age _____ Referral from: _____

EMAIL ADDRESS: _____

US Citizen (or lawfully residing in the US for at least 5 years) ☐ Yes ☐ No

Guardian/Emergency Contact Person: _____ Phone: _____

Address: _____ Relationship: _____

Demographic Information (optional) Hispanic: ☐ Yes ☐ No

Marital Status: ☐ Divorced ☐ Married ☐ Separated ☐ Single ☐ Widow(er)

Heritage: ☐African American ☐Caucasian/White ☐Native American ☐Other _____

If the need arises: Do you have a primary medical doctor? ☐ Yes ☐ No Dentist? ☐ Yes ☐ No
If you see a dentist, how will it be paid for?_____

Contact Information: Check all that apply

May we contact you: ☐ Home/Cell ☐ Home (write) ☐ Text/e-mail ☐ Work (call)

Can we leave a message if we call you? ☐ Yes ☐ No

Can we identify ourselves if we call you? ☐ Yes ☐ No

Restrictions in contacting you: _____

Monthly Income (for applicant only):

Earnings: Employer(s) or Self Employment _____ $_____

Disability, Social Security, Unemployment Compensation, Work study, Scholarships
or other income _____ $_____

Office Use Only **Monthly Total** $_____

Fee Level _____

We are required by our funding sources to enroll each patient into programs that he or she is eligible for. If you are not eligible for (or choose not to apply for) care funded through Family Planning Only Services, payment will be expected at the time of service.

Would you like to apply for Family Planning Waiver (Medical Assistance) ☐ Yes ☐ No

Please provide a photo ID and check-stubs from the last month.

This will be a **TEMPORARY ENROLLMENT**. Please watch your mail as you will receive notice from the State of Wisconsin if they need any further information. **Failure to follow through on your application, or failure to complete an annual review, may cause delays and out of pocket expense to you for future services**.

How are you going to pay for today's services?

Insurance ☐ _____

Policy # _____ Group # _____

Please provide a copy of the front and back of all insurance cards

Private Pay ☐ Cash ☐ Check/Money order #_____

Please read and initial the following statements:

____ Information you supply is confidential. We will ask you to sign a privacy notice which describes how medical information about you may be used and disclosed.

____ I freely consent to become a client and request the appropriate medical procedures to meet my reproductive and/or sexual health care needs.

____ I am aware there are charges for services received from the Family Planning Clinic. There will not be an out of pocket expense to me if my insurance covers all services.

____ Waupaca County will submit billing directly to my insurance company with payments going directly to Waupaca County.

____ If I do not have insurance, or there is a balance on my account after my insurance has paid, charges will be based on my ability to pay using the State sliding fee scale. Failure to provide required information on my household (for purpose of placement on sliding scale) will result in the maximum charges being charged to me.

___ For billing questions I may contact the billing Clerk directly at 715-258-6319.

_____ _____

Client Signature Date

11-08-17