

ADULT ADMISSION RECORD

DATE: _____

NAME: _____
Last First Middle

SOCIAL SECURITY NUMBER: _____ - _____ - _____ BIRTH DATE: _____

ADDRESS: _____
Street Address City State Zip

TELEPHONE: _____ - _____ - _____ CELL PHONE: _____ - _____ - _____

EMERGENCY CONTACT: _____ EMERGENCY PHONE: _____ - _____ - _____

EMPLOYER: _____ PHONE: _____ - _____ - _____

Please check the appropriate boxes. ("Race" is optional.)

- | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>RACE: <input type="checkbox"/> African American or Black
 <input type="checkbox"/> Asian
 <input type="checkbox"/> Hispanic or Latino
 <input type="checkbox"/> Mixed
 <input type="checkbox"/> Native American/Indian
 <input type="checkbox"/> White
 <input type="checkbox"/> Other
 <input type="checkbox"/> Unknown</p> | <p>SEX: <input type="checkbox"/> Male
 <input type="checkbox"/> Female</p> | <p>FINANCIAL: <input type="checkbox"/> Employed
 <input type="checkbox"/> Unemployed
 <input type="checkbox"/> Self-Employed
 <input type="checkbox"/> Retired
 <input type="checkbox"/> Disabled
 <input type="checkbox"/> Student</p> |
| <p>MARITAL STATUS: <input type="checkbox"/> Single
 <input type="checkbox"/> Married
 <input type="checkbox"/> Divorced
 <input type="checkbox"/> Legally Separated</p> | | |

HOUSEHOLD:

Own Rent Temporarily Living with Family/Friend Agency: _____
(example: Salvation Army)

Total Number of persons in household: _____ No. of minor children _____ No. of Adults _____ No. persons with income _____

ARE YOU CURRENTLY COVERED UNDER ANY OF THE FOLLOWING?

Health Insurance Medicaid Medicare Veteran's Health Benefits Worker's Compensation

PROOF OF WAYNE COUNTY RESIDENCY FROM ONE OF THE FOLLOWING – COPIED AND PLACED IN CHART:

Utility Bill Rent Receipt Lease Pay Stub with Home Address Letter from Agency Other

PROOF OF INCOME FROM ONE (OR MORE) OF THE FOLLOWING – COPIED AND PLACED IN CHART:

1040 **plus** Pay Stub Unemployment SS Income/Disability Food Stamps Pension Child Support/Alimony Other

PARTICIPATION AGREEMENT:

I verify that all of the above information is true. I understand that I will be denied some or all services if:

(Initial each statement, sign and date)

- _____ My income exceeds the income limit.
- _____ I do not live in Wayne County.
- _____ I have Medical coverage of any type.
- _____ I do not provide the Proof of Income and Residency documents requested.
- _____ I do not comply with the rules of the Medication Assistance Program. (Medications available through MAP will not be sampled or vouchered due to non-compliance.)

Signature: _____ Date: _____