

CHILD ADMISSION RECORD

DATE: _____

NAME: _____
Last First Middle

SOCIAL SECURITY NUMBER: _____ - _____ - _____ SEX: Male Female BIRTH DATE: _____

ADDRESS: _____
Street Address City State Zip

PARENT'S NAME: _____
Last First Middle

PARENT'S SOCIAL SECURITY NUMBER: _____ - _____ - _____

PARENT'S ADDRESS: (IF DIFFERENT) _____

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

EMPLOYER: _____ PHONE: _____ - _____ - _____

CHILD'S INSURANCE INFORMATION:

Health Insurance Medicaid

PARENT'S 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 _____

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)

_____ Household 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: _____

Relationship to Patient: _____