COMMUNITY HEALTH MINISTRY Patient #

Client Information

Last Name (please print) **First Name** **Middle Initial** **Date of Birth**

Physical Address (Not P.O. Box) **City** **County** **Zip Code**

Previous Address (if less than **3** months) **Address** **City** **Zip Code**

Social Security # **Referral Source**

Telephone	May we leave a message?	May we text you?		May we email you?
Home	☐ Yes ☐ No		Email address to receive updates on food distributions or special giveaways	☐ Yes ☐ No
Cell	☐ Yes ☐ No	☐ Yes ☐ No		

U.S. Citizen	Legally Disabled	Veteran	Gender	Ethnicity	Race
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Male ☐ Female ☐ Transgender	☐ Hispanic ☐ Non-Hispanic	☐ Native American ☐ White ☐ African American ☐ Asian ☐ Other

Marital Status	☐ Single	☐ Married	☐ Divorced	☐ Widowed	☐ Cohabitating
Employment Status	☐ Full-time ☐ Part-time	☐ Stay-at-home parent	☐ Retired ☐ Student	☐ Disabled ☐ Unemployed	☐ Other

Medical, Dental and Counseling appointments require a copay per visit.

Insurance

Health	Yes No	Type	Doctors Name	
Dental	Yes No	Type	Dentist Name	

Amount: $_____ **Income Source/Employer**_____ **# in Household** _____

I certify that the information provided is accurate and complete and I understand that I must provide income verification in order to receive services from Community Health Ministry, a Charitable Provider under KSA 75-6120.

SIGN HERE

Signature **Date**

'OR' Signature of Authorized Legal Guardian _____ Date_____

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Medical History

Name _____
Date of Birth _____
Pharmacy _____

1. Does anyone in your household have any diet requirements or food allergies? Yes No
   If yes, list name of household member(s) and explain:
   _____

2. Are you allergic to:
   Medications? Yes No
   Local anesthetics? Yes No
   Latex? Yes No
   If yes for any of the above, please list _____

3. Have you been seen by a medical doctor in the last two years? Yes No
   If yes, for what? _____
   Name of Doctor_____

4. Have you have you been hospitalized in the last 5 years? Yes No
   If yes, please explain _____

Immunization History

Last Tetanus Shot _____ Last Pneumonia vaccination_____ Last Flu Shot _____

Current Medications

Name	Dose	Frequency	Reason for Medication

Please circle any of the following you have had, or have at present.

ADHD
Alzheimer's/Dementia
Anxiety/Depression
Bipolar Disorder
Epilepsy/Seizures
Panic Attacks
Schizophrenia/Psychosis

Allergies/Hay Fever
Asthma
Emphysema/COPD
Tuberculosis
Cancer: _____

Thyroid Problems

Anemia
Bowel Problems
Heartburn Reflux
Stomach Ulcer

Arthritis
Fibromyalgia
Chronic Pain

MRSA Infection
Hepatitis: _____
HIV/AIDS
Blood Transfusion
STD's

Liver Trouble

Diabetes

Urinary Infection
Kidney Stone

High Blood Pressure
Heart (Surgery, Disease, Attack)
Artificial Heart Valves
Bleeding/Clotting Problems
Artificial Joint (Knee, Hip, Shoulder)
Pacemaker

Other: _____

Social History

On average, how many alcoholic beverages do you consume per week? _____
Do you use tobacco products? Yes No

Surgical History

Operation	Surgeon	Date

Family Medical History

(Relationship and Date of Onset)

Cancer _____ Heart Attack _____
Stroke _____ Diabetes _____
Bleeding/Clotting _____ Thyroid _____
Kidney _____ Other _____

Female History

Are you pregnant: Yes No Due Date _____
Are you nursing: Yes No
Date of last menstrual period _____

Signature_____ Date _____

What are your **current living arrangements?**

☐ Own home ☐ Renting landlord's name: _____ ☐ Homeless ☐ Temporarily living with friends or relatives

Highest **level of education completed?** ☐ PreK - 6th grade ☐ 7th – 12th grade ☐ Completed High School/GED ☐ College/Professional Training

Other education (please be specific):

_____

List *all other* members in the household (*besides yourself*)

Full Name	Social Security #	M/F	Date of Birth	Relationship	Race	Veteran or Disabled	Health Insurance

Relative or Friend to contact in the event of an emergency: _____ **Phone:** _____

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Income/Eligibility Verification

For all '<u>EMPLOYED</u>' members of the household, please list MONTHLY income amounts:

Name of Household Member	Rate of Pay	Source of Income
	$ per **<u>Month</u>**	
	$ per **<u>Month</u>**	
	$ per **<u>Month</u>**	
Grand Total Amount:		

Benefit Sources	Amount per Month	Name of Household Member
Unemployment	$	
Social Security Income	$	
Social Security Disability Income	$	
Veteran's Disability Income	$	
Worker's Comp	$	
TANF/Cash Assistance	$	
Retirement/Pension	$	
Child Support	$	
Alimony/Spousal Support	$	
SNAP/Food Stamps	$	
Other	$	
Medicaid	Yes No	
Medicare	Yes No	
TFAP Commodities	Yes No	
Section 8/Public Housing	Yes No	
VA Medical Services	Yes No	
WIC	Yes No	
LIEAP (Seasonal)	Yes No	

Monthly Expenses

(Staff will total expenses)

Credit Cards	$	Child Care	$	Clothing	$	Child Support	$
Education	$	Electricity	$	Entertainment	$	Food (Not Food Stamps)	$
Garnishments	$	Household Gas	$	Health Ins.	$	House/Car Ins.	$
Laundry	$	Legal	$	Medical	$	Mortgage	$
Prescriptions	$	Payday Loans	$	Rent	$	Retirement	$
Storage	$	Savings	$	Car Payment	$	Phone	$
Gas for Car	$	Car Repair	$	Taxes	$	Water	$
Sewer/Trash	$	Liquor/Tobacco	$	Pets	$	Internet/Cable	$
Total	$	**Total**	$	**Total**	$	**Total**	$
						Grand Total	

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge I have been offered a copy of Community Health Ministry's Notice of Privacy Practices. **I certify that the information provided on this page is true and correct to the best of my knowledge.**

Print Client Name	Client Date of Birth
Signature of patient (or parent/guardian)	Date
Relationship to Client	

Inter-Staff Waiver of Confidentiality

I understand that the goal of Community Health Ministry (CHM) is to maximize the overall health of its clients – body, mind, and spirit. In order to take a "whole-person approach", it is helpful to have authorization to allow verbal communication between CHM staff members. By signing below, I am waiving / giving up my right to confidentiality for coordinating my care. Staff members include Medical Doctors, Nurse Practitioners, Registered Nurses, Dentists, Hygienists, Social Workers, and Marriage and Family Therapists. Communication might also include the Social Department Supervisor and Executive Director of CHM. Each professional will use discretion in determining what information should be shared.

Other Agency Waiver of Confidentiality

I also give my permission to CHM to contact other agencies or organizations who are offering me services, in order to coordinate my care. I further authorize these agencies to release relevant information to CHM.

Mandatory Reporters

I understand that licensed professionals are **required to report** if:

- They have reasonable suspicion that there may be abuse or neglect of a child or of a dependent or elderly adult;
- A client communicates a threat of bodily injury to self or others; or
- A court orders that information be provided or testimony given.

Missed or Cancelled Appointment Policy

I understand that any time CHM is not given 24-hour's notice of a cancelation it wastes valuable resources. It is discouraging to volunteer doctors, dentists, or counselors if clients are late or do not show up for an appointment. **It is your responsibility to notify CHM if you need to cancel an appointment by calling (785) 456-7872 during office hours**. **THREE** broken appointments in a six (6) month period results in losing the ability to schedule any further routine appointments for six (6) calendar months. **However, I understand I will be allowed to come in on clinic days and wait to be seen if there is a break in the schedule.**

Student Clinicians

I hereby consent to receive treatment from a student(s). I understand that all treatment will be under the direct supervision of a Licensed Professional. I have a right to refuse treatment by a student clinician.

Right to Cancel

I understand that I have the right to cancel any authorization given to CHM, except in regards to action that has already been taken. I will give written notice if I need to make any changes.

Client Signature **Date** **CHM Staff Initials**

Client Consent and Release of Information

MAACLink is a computer system that is used locally as a Homeless Management Information System (HMIS). Use of an HMIS is required by the US Department of Housing and Urban Development (HUD) for agencies that receive HUD funding. MAACLink is not electronically connected to HUD and is only used by authorized agencies. All MAACLink users have received confidentiality training and have signed strict agreements to protect clients' personal information and limit its use appropriately.

A Privacy Notice is available at participating agencies. It provides details on how member agencies and their employees handle client information and data sharing.

I give permission to ***Community Health Ministry*** (Agency Name) to collect, access, and enter my personal and household information into the MAACLink computer system.

I understand that the MAACLink system is shared with and used by authorized agencies in my community for the purposes of:

1. Assessing the needs of low-income, homeless or other people with special needs in order to give better assistance and to improve their current or future situations.
2. Improving the quality of care and service for people in need.
3. Tracking the effectiveness of community efforts to meet the needs of people who have received assistance.
4. Reporting data on an aggregate level that does not identify specific people or their personal information.

I understand that:

- All agencies that use MAACLink will treat my information in a professional and confidential manner.
- Signing this release form does not guarantee that I will receive assistance.
- My information may be shared with a third party (utility provider, landlord, etc) in order to process the service I have requested.
- I have the right to a printed copy of my MAACLink file.

☐ (Optional) Check this box to give consent for your photo to be uploaded to MAACLink.

Client Name (Printed)	**Client Signature**	**Date**
Agency Representative Name (Printed)	Agency Representative Signature	Date

Agency Representative:

☐ Check this box if you were unable to obtain the client's signature and verbal consent was given in its place.

Each MAACLink agency will ask you to sign this form at least annually. If after you give consent you decide you no longer would like your information entered into MAACLink, please complete the Client Revocation Form. If you do not revoke this authorization, it will automatically expire on 7/1/19 *or one year from the date you sign and date this form.*