Will County
Health Department &
Community Health Center

# WILL COUNTY COMMUNITY HEALTH CENTER
# DECLARATION OF INCOME

PLEASE PRINT:

Last Name: _____ First: _____ M.I. _____

Address: _____ City: _____ State: _____ Zip Code: _____

Email: _____ Phone: _____ Gender: Male □ Female □

Date of Birth: _____ SSN: _____
MM DD YYYY

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Housing: Rent Own Doubling Up Homeless Shelter Street Transitional Unknown Other

Race: (circle) White Asian Black/African American Native Hawaiian Pacific Islander
American Indian/Alaskan Native More than one race Other

Ethnicity: (circle) Hispanic Non-Hispanic Veteran: (circle) Yes No

Language Barrier: (circle) Yes No Preferred Language: _____

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Family Size: (Include yourself, spouse, and dependent children under the age of 18) _____

*Income: Yes □ No □ Income Amount: $ _____ Weekly □ Bi-Weekly □ Monthly □ Yearly □

**Proof of Income or no income is required by staff to update every 12 months.*

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Please check all sources of income:

□ I am employed/my spouse is employed
□ Unemployment Benefits
□ Social Security
□ Social Security Disability
□ Supplemental Social Security Income
□ Unemployed, No Proof of Income Provided
□ Food Stamps
□ Alimony
□ Child Support
□ Pension

Employer's Name: _____

Employer's Address: _____

_____

City: _____ State: _____ Zip: _____

I hereby attest that the information provided above is complete and true to the best of my knowledge.

_____ _____
Patient Signature Date

_____ _____
Witness Date

Medical Record Number: _____ Registered by: _____

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# WILL COUNTY COMMUNITY HEALTH CENTER

## Acknowledgement of Receipt of Joint Notice of Privacy Practices

Our Joint Notice of Privacy Practices ("Notice") provides information about: 1) the privacy rights of our patients; and 2) how we may use and disclose protected health information about our patients. Federal regulations require that we give our patients or their authorized representatives our Notice before signing this acknowledgment.

By signing this form, you are only acknowledging that you have been provided our Notice.

_____ _____

Patient/Authorized Representative Signature Date

_____

Print Name of Patient/Authorized Representative

Authority of Representative to Sign for Patient (Please check one)

□ Parent □ Guardian □ Power of Attorney

□ Other:_____

5-2-2019

## WILL COUNTY HEALTH DEPARTMENT & WILL COUNTY COMMUNITY HEALTH CENTER

# CONSENT FOR MEDICAL AND BEHAVIORAL HEALTH EVALUATION AND TREATMENT

**Medical Consent**: I authorize Will County Health Department & Will County Community Health Center and its medical, dental, behavioral health, and other professional staff members, to provide such health care services and administer such diagnostic and therapeutic procedures and treatments as deemed necessary or advisable in my care. This includes all routine diagnostic tests and procedures, including but not limited to: the administration and/or injection of pharmaceutical products and medications and the withdrawal of blood for laboratory examination. I understand that no guarantees have been made to me as to the results or effectiveness of treatment or examinations performed at Will County Community Health Center. I understand that this consent is valid for up to 1 year and that I may stop services at any time I feel it is necessary.

In the course of treatment, treatment may be provided by a student of nursing, medical assistant, or behavioral health student. I will be informed if a student is working with me and I have the right to decline their services.
_____ **(initials) I do not wish to have students provide my care.**

**Release of Information**: I authorize Will County Health Department/Will County Community Health Center to use and disclose my health information for the following purposes: (1) to provide for, arrange or coordinate my health care treatment; (2) to enable Will County Community Health Center to obtain payment for the services provided; and (3) to permit Will County Community Health Center to carry out ordinary health care and business operations such as quality assurance, service planning, and general administration. I am aware that this authorization to use and disclose information may include information regarding:

- HIV or AIDS
- Mental illness or any mental health disorder
- Family planning, pregnancy
- Alcohol or substance use disorders/Treatment
- Sexually transmitted diseases
- Genetic tests or genetic diseases

I am aware that Will County Community Health Center may share information with any of my other medical providers for medical treatment or with a third party for financial payment through electronic means.

**Assignment of Benefits**: I assign to Will County Community Health Center all benefits to which I may be entitled from Medicare, Medicaid, other government agencies, insurance carriers, and other third parties who are financially liable for medical care, behavioral health services, or any other treatment provided by Will County Community Health Center.

**Financial Obligations**: In the event of non-payment by a third party for which I have provided an assignment of benefits, I am obligated to pay all amounts due for services provided at Will County Community Health Center facilities in accordance with the rates and terms of Will County Community Health Center in effect on the date of service. I also agree that I am responsible for any applicable copayments, coinsurance, or deductibles.

I certify that I have read this form and that I am the patient, or I am duly authorized by the patient, as the patient's representative to execute this form and accept its terms.

Patient or Responsible Party Name (Print): _____

Patient or Responsible Party (Signature): _____

Relationship to Patient (if patient is unable to sign): _____

Date: _____ Witness: _____
(Print & Signature)

Patients under the custody of DCFS must have a "Routine and Ordinary" consent signed by DCFS representative for medical care and a "Mental Health Treatment" consent to receive B.H. services
(4-2020)