Child Sceening Form
Date_____

Third City Community Clinic
1107 N. Broadwell
Grand Island, NE 68803

Name_____
Last First Middle Initial
Address_____City_____Zip_____
County_____SS#_____-_____-_____Age_____Sex_____
Date of Birth_____-_____-_____Telephone:_____

Parents' names:_____Message Phone_____
Race: Hispanic_____ Education Level: Preschool_____ Grade_____
White _____ 9 or < _____ Proof of Income_____
Asian _____ 10-11 _____ Taxes_____
Black _____ 12 _____ Medicaid denial letter_____
Am I _____ GED _____
Other _____ UNK _____ Language Spoken_____

HOUSEHOLD FINANCIAL INFORMATION

Medicaid-------Y or N Health Insurance----------Y or N
Assistance_____(ADC, SSI, Unemployment, Disability, Child Support,
WIC, Social Security, Alimony) Food Stamps_____
Have you made an application for any of the above?----------Y or N
If yes, what?_____ and when?_____
Do you rent or own a home? Monthly payment_____
Other financial resources?_____Other income?_____
Total number in household_____Number of Children under 18_____

Occupation Information:

	Name of Employer	Unemployed	Wages/HR	Hrs/WK	TOTAL
Father:					
Mother:					
Other:					
Other:					

Monthly Household Income before taxes_____

MEDICAL INFORMATION

Does the child have a physician?----------Y or N
What physical problem brings you to TCCC today?_____
Have you seen a physician about this problem?_____
If yes, the name of the physician_____

At least a $5.00 donation is requested at each visit if you are able to give. I agree to provide proof of income if requested. I understand that the above information may be verified and that the information is complete and accurate.

Signature of patient_____

Screener_____Date_____