



Leading you to better health!

THE FOLLOWING INFORMATION WILL HELP YOU USE OUR SERVICES MORE FULLY:

1. Do you have hearing/vision issues that require assistance from our staff?

- Yes • No

2. Check any that apply:

- Veteran • Migrant • Seasonal Worker • Public Housing • Homeless

3. Do you need assistance with transportation to/from our Health Center?

- Yes • No

4. Household Income \$_____ • Yearly • Monthly • Weekly

Number of People in Household _____

5. Would you like assistance applying for Medicaid or the Healthy Indiana Plan?

- Yes • No

6. Would you like to apply for the Sliding Fee Scale at WHN?

(Income based program for discounted patient fees) For questions see WHN staff member.

- Yes • No

Patient Name _____

DOB: _____

Signature _____

Date: _____

WHN Staff Member: _____

Date: _____