WindRose Health Network

"... leading you to better health"

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

1. **Do you require a translator? YES NO**

2. **Would you like assistance applying for Medicaid or the Healthy Indiana Plan (HIP 2.0)?**

   YES NO

3. **Do you need assistance with transportation to/from our Health Center? YES NO**

Patient Name _____ **DOB:** _____

Signature _____ **Date:** _____

WHN Staff Member: _____ **Date:** _____