



# Family Health Care

## Baldwin • Cadillac • Grant • McBain • White Cloud

[www.familyhealthcare.org](http://www.familyhealthcare.org)



Today's Date: \_\_\_\_\_

Dear Patient,

Family Health Care is designated as a Federally Qualified Health Center (FQHC). An FQHC receives additional funding from the federal government to extend medical care to uninsured/underinsured patients. One requirement of this designation is for the clinic to gather additional information about all of our patients to help determine if community medical needs are being met. In order for us to continue to serve our community, we request that you please take a moment to complete the following information:

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Race:**

- |   |                                |   |
|---|--------------------------------|---|
| <input type="checkbox"/> African American/Black | <input type="checkbox"/> White | <input type="checkbox"/> Native Hawaiian        |
| <input type="checkbox"/> American Indian        | <input type="checkbox"/> Asian | <input type="checkbox"/> Other Pacific Islander |

**Ethnicity:**

- I consider myself to be Latino/Hispanic

**Sexual Orientation:**

- |                                   |                                   |                                      |                                     |   |
|-----------------------------------|-----------------------------------|--------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Straight | <input type="checkbox"/> Bisexual | <input type="checkbox"/> Lesbian/Gay | <input type="checkbox"/> Don't Know | <input type="checkbox"/> Something else |
|-----------------------------------|-----------------------------------|--------------------------------------|-------------------------------------|---|

**Gender Identity:**

- |                                 |  |                                |
|---------------------------------|--|--------------------------------|
| <input type="checkbox"/> Male   | <input type="checkbox"/> Transgender female/male to female | <input type="checkbox"/> Other |
| <input type="checkbox"/> Female | <input type="checkbox"/> Transgender male/female to male   |                                |

**Please check all that apply:**

- |  |  |
|--|--|
| <input type="checkbox"/> Military Veteran                                      | <input type="checkbox"/> Seasonal/Migrant Worker             |
| <input type="checkbox"/> Dependent of Seasonal/Migrant Worker                  | <input type="checkbox"/> Primary Language other than English |
| <input type="checkbox"/> Require Translation Services _____<br>Native language | <input type="checkbox"/> Homeless                            |

**Family Size:**

Family Size or Household Size is described as persons living under one roof in an interdependent relationship. All members of a household should be reflected on the IRS - 1040 of the Head of the Household

- |  |  |
|--|--|
| <input type="checkbox"/> 1 Household Member  | <input type="checkbox"/> 6 Household Members |
| <input type="checkbox"/> 2 Household Members | <input type="checkbox"/> 7 Household Members |
| <input type="checkbox"/> 3 Household Members | <input type="checkbox"/> 8 Household Members |
| <input type="checkbox"/> 4 Household Members | <input type="checkbox"/> 9 Household Members |
| <input type="checkbox"/> 5 Household Members | <input type="checkbox"/> Other Family Size   |

**Household Income Data:**

Data regarding Household Income will not be reported specific to any person or patient. Required reporting aggregates the number of patients of the health center into groups as a percentage of the Poverty Level.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> \$0 - \$10,000      | <input type="checkbox"/> \$70,001 - \$80,000   | <input type="checkbox"/> \$140,001 - \$150,000 |
| <input type="checkbox"/> \$10,001 - \$20,000 | <input type="checkbox"/> \$80,001 - \$90,000   | <input type="checkbox"/> \$150,001 - \$160,000 |
| <input type="checkbox"/> \$20,001 - \$30,000 | <input type="checkbox"/> \$90,001 - \$100,000  | <input type="checkbox"/> \$160,001 - \$170,000 |
| <input type="checkbox"/> \$30,001 - \$40,000 | <input type="checkbox"/> \$100,001 - \$110,000 | <input type="checkbox"/> \$170,001 - \$180,000 |
| <input type="checkbox"/> \$40,001 - \$50,000 | <input type="checkbox"/> \$110,001 - \$120,000 | <input type="checkbox"/> \$180,001 - \$190,000 |
| <input type="checkbox"/> \$50,001 - \$60,000 | <input type="checkbox"/> \$120,001 - \$130,000 | <input type="checkbox"/> \$190,001 - \$200,000 |
| <input type="checkbox"/> \$60,001 - \$70,000 | <input type="checkbox"/> \$130,001 - \$140,000 | <input type="checkbox"/> Over \$200,000        |

**This institution is an equal opportunity employer and provider.**

**Form #2020**  
07-19-17