CLIENT APPLICATION

Please complete both sides

Date: _______________

General Information

Name: ___________________________ Home Phone #: _____________ Work Phone #: _____________

Address: ______________________________ City: ________________ State: _____ Zip: __________

2) Present Household/ Family

Options: Married, Single, Co-habiting, Separated, Divorced, Widowed

Options: White, African American, Hispanic, Native American, Asian, Other

Full Name (no nicknames)	Birth Date Mo/Day/Yr	Relationship to You	Marital Status	Education Level	Race/ Ethnicity	Living at home? (Yes or No)	Social Security #
CLIENT NAME HERE		self					

If client is under the age of 18, please provide mother's maiden name: ____________________

May we call to remind you of upcoming appointments? ☐ Yes ☐ No
If yes, at what number? (_______) ________________

3) Personal Profile

◦ Do you speak English? ☐ Yes ☐ No If no, what language do you speak? _____________________

Emergency Contact Person: _________________
Address: _____________________
____
Phone #: _____________________

Child under DCFS Guardianship: ___________
Foster Parents: _____________________
Address: _____________________
____
Phone #: _____________________

IDCFS Case Worker: _____________
Address: _____________________
____
Phone #: _____________________

PLEASE COMPLETE REVERSE SIDE ⇒

Please complete the following information if you will be using ALL KIDS or wish to apply for our sliding fee scale. If you do not wish to complete this information, you will be responsible for paying the full fee.

Income #1 (Yourself)

Annual Gross Income $__________________

Income #2 (Spouse/Partner)

Annual Gross Income $__________________

Additional income

Such as part time employment, second job, public aid, unemployment, child support, interest, other:

Type: ________________ Annual Total: $__________________

Type: ________________ Annual Total: $__________________

TOTAL ANNUAL HOUSEHOLD INCOME: $__________________

FOR OFFICE USE ONLY

Attestation of Consumer Monthly Income

Consumer Name: __________________________________
Last First Middle

RIN: ______________ Household Size: ______ persons

Gross Monthly Household Income: $________________

Source: ________

D = Document (pay stub, tax form, etc.)
C = Consumer attestation
G = Consumer parent or guardian attestation
P = Provider attestation

Signature: ______________________ Date: ___________

A. Please file claims to my insurance company according to the information I have provided below:

Employee ____

Soc. Security # and/or ID# ____________________Group #________

Name of Insurance Company ________________________________

Insurance Company Phone # ________________________________

Insurance Company Address ________________________________

City: __________________ State: ______ Zip: __________

The insured or authorized person's signature is required if you are using your insurance benefits for:

1. The release of any medical or other information necessary to process this claim.
2. The payment of medical benefits to TriCity Family Services who accepts assignment for its services.

SIGNED ______________________________ DATE _______________

B. Please answer the following questions:

1. If the client is under 18, do they currently have an ALL KIDS Card? ☐ Yes ☐ No
   If yes, indicate the ALL KIDS Number: ____________________
2. Are you currently enrolled in Medicare? ☐ Yes ☐ No
   If yes, indicate your Medicare Number: ____________________
3. Are you currently applying for or receiving SSI/SSDI?
   ☐ Yes ☐ No
4. Are you currently enrolled in CILA, ACT, DFI? ☐ Yes ☐ No

C. Have you sought help in obtaining any of the following services:

☐ Not Applicable
☐ Residential/Living Arrangements
☐ Vocational Rehabilitation
☐ Transportation
☐ Medical
☐ Substance Abuse Treatment
☐ MH Case Management
☐ Hospitalization
☐ Other _______________
☐ Unknown

Please attach a copy of your Insurance/ALL KIDS/Medicare card