

Morris County Health Department  
Income and Demographic Data

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Street City Zip County  
Phone (H#) \_\_\_\_\_ (C#) \_\_\_\_\_ Message # \_\_\_\_\_

Emergency contact person \_\_\_\_\_ Phone # \_\_\_\_\_

May we contact you at the above address? YES  NO  May we contact you at the above phone number(s)? YES  NO   
If NO how may we contact you? \_\_\_\_\_ Sex: Male  Female

Race (mark all that apply):

White  Black or African American  American Indian /Alaskan Native  Asian   
Native Hawaiian /Pacific Islander  Unknown/not Reported

Origin: Hispanic/ Latino? Yes  No

Circle one: Mexican Cuban Puerto Rican Central or South American Other/Unknown

Primary Language English Yes  No  Number of persons living in your home \_\_\_\_\_  
Who is your major source of income? Self  Spouse  Parents  Other

Client's Primary type of Health Coverage:

Medicaid  Health Wave  Other Public Insurance  No coverage  Unknown  Private Insurance

Insurance provider name: \_\_\_\_\_ Group # \_\_\_\_\_ Member # \_\_\_\_\_

List below **ALL** members of your household with income {**gross** income before withholding.}

Ex., commissions, net income for farm and self employment etc.}

Name	Place of employment	Gross Income/How Often	Total
1. _____			
2. _____			
3. _____			

List other income {child support, SRS, Cash Assistance, Alimony, Unemployment, Workmen's Compensation, College and University scholarships, Grants, Fellowships and Assistantships, etc.}

Fee for services are based on the cost of providing services and are subject to change. Discounts are available based on gross income. \$ \_\_\_\_\_ per wk X 52, \$ \_\_\_\_\_ qowk X 26 or \$ \_\_\_\_\_ qmo X 12= \$ \_\_\_\_\_ yr  
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I understand that I will be billed for \_\_\_\_\_% of the fees for the services I receive.

I hereby certify that the above information is correct of the best of my knowledge, and I have not knowingly withheld any information. I understand that if my income or number of household members changes I must notify the Morris County Health Department at my next client visit.

**I ACKNOWLEDGE THAT I HAVE HAD THE OPPORTUNITY TO REVIEW A COPY OF MORRIS COUNTY HOSPITAL'S NOTICE OF PRIVACY PRACTICES WITH THE EFFECTIVE DATE OF APRIL 14, 2003.**

\_\_\_\_\_  
Clients Signature

\_\_\_\_\_  
Date