MATERNAL AND FAMILY HEALTH
FINANCIAL INFORMATION FORM

Client's Name: _____ **Date of Birth:**_____
Last First MI

Client's Address: _____
Physical Address City State ZIP

_____
Home Phone # Mailing Address (if different) City State ZIP

A. MEDICAL INSURANCE INFORMATION (attach a copy of their insurance, Medicaid and/or Kid Care Chip card if available.)

If a parent, who is not living in the house, is required to carry health insurance *or* assist with medical bills for the client, please provide us with the NAME/ADDRESS of this parent: _____
and Insurance Company/Policy #: _____

Insurance	Name of Company	Covers Client's Condition:	Policy Number/Holder Name	Deductible & Co-Pay	Premiums Payment
Primary		☐ Yes ☐ No			
Secondary		☐ Yes ☐ No			
Dental		☐ Yes ☐ No			
Orthodontic		☐ Yes ☐ No			
Medicaid / Kid Care CHIP	**Client Number**: _____ **Eligibility Date**: _____				

B. FAMILY INCOME Include **all income from client, spouse, parent(s), stepparent, legal guardian(s) or adult who LIVE in the house.** A copy of your income tax form or W-2's may be requested. **If self-employed, please send your most recent income tax form**.

Total Number of Family Members Living in the Household (required): _____

Household Income Information	Relationship to client_____	Relationship to client_____
Occupation		
Current Employer and how many months of the year are you employed?	_____ **Months:**	_____ **Months:**
Month/Years at Current Job		
Monthly Gross Earnings (before taxes & deductions)		
Amount in Savings		
Child Support, Alimony or Family and/or Military Benefits Received		
Social Security - SSI, SSDI, Retirement, or Survivors Benefits Received		
Other Income: Dividends/Interest, Business Income (i.e. Rental income), Real Estate, Royalties, Pensions, Annuity Payments, Estates/Trusts		
Unemployment, Workman's Compensation, Strike Benefits, Training Stipends		
EXPENSE: Child Support Paid Out		

Continued on Back

MATERNAL AND FAMILY HEALTH
FINANCIAL INFORMATION FORM (cont.)

C. CITIZENSHIP (required):

U.S. Citizen? YES or NO (please circle)

If NO, Date of entry _____ Non-Citizen / Alien Registration Number _____
Month/day/year

My signature certifies that the citizenship/immigration status is correct for the applicant. I do not have to give information on citizenship or immigration status of family members who are not applying for healthcare benefits. I understand that my records will be kept confidential and will only be released for purposes authorized by you or required by federal and state law. Information I provide on this application is not routinely provided to Immigration and Naturalization Service (INS).

I (We) apply for care of _____ by Maternal and Family Health (MFH). It will be a financial difficulty to pay for the recommended services. I will apply all hospital and/or medical insurance benefits I receive to the cost of my/child's care. For those applying for Maternal High Risk (MHR) or Children's Special Health (CSH) program, I understand that Maternal and Family Health must give prior authorization for any care for which MFH is to pay.

The information you have provided will remain confidential with the Wyoming Department of Health EXCEPT in the following circumstances:

> Maternal and Family Health as part of the Wyoming Department of Health is a covered entity. MFH may request from any state agency, insurer, group health plan, health maintenance organization or similar entity any or all of your protected health information. This information may be used or disclosed for the process of treatment, payment or healthcare operations. This is in accordance with the Health Information Portability and Accountability Act section 164.502(a)(1)(ii). Please see your client Privacy Rights Policy for use and disclosure of your protected health information.

All information I have given on the confidential financial statement and application is true to the best of my knowledge.

I understand this authorization may be revoked in writing at any time. The recipient of this information might disclose it to other people. This consent/release is valid for one (1) year while receiving these services. A photocopy or reproduction of this authorization is as valid as the original.

Parent/Guardian/Client Signature: _____ Date: _____

Please notify your Public Health Nurse/Care Coordinator immediately of any changes in insurance.