FAMILY SERVICE AND GUIDANCE CENTER, INC
CLIENT INFORMATION FACE SHEET

PLEASE ANSWER ALL SECTIONS. FOR ASSISTANCE, INQUIRE AT THE FRONT WINDOW.

CLIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: **_____Social Security Number: _____ Alias Name(s): _____**

Gender: ____Male ____Female ____Transgender-Male to Female ____ Transgender-Female to Male

Address: _____
Street City County State Zip Code

Birth Last Name: _____ **Home Phone**: _____

Cell Phone: Name**: _____ #: _____** Name: **_____ #: _____**

Marital Status: ____Never Married ____Married ____Divorced ____Separated ____Widowed ____Common Law

Race: ___ American Indian or Alaska Native ___Black or African American ___Native Hawaiian or Other Pacific Islander
___ Asian ____White ___Other / Unknown:_____

Ethnicity: Hispanic / Latino ___YES ___ NO

Employer: _____ **Occupation**:_____ **Work Phone**:_____

INSURANCE INFORMATION
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Primary Insurance Company's Name: _____ (Includes Medicaid and Medicare)

Group Name: _____ Group ID #: _____

Plan Name: _____ Plan ID# _____

Insured's Name:_____

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Secondary Insurance Company's Name: _____ (Includes Medicaid and Medicare)

Group Name: _____ Group ID #: _____

Plan Name: _____ Plan ID# _____

Insured's Name:_____

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Third Insurance Company's Name: _____ (Includes Medicaid and Medicare)

Group Name: _____ Group ID #: _____

Plan Name: _____ Plan ID# _____

Insured's Name:_____

Primary Care Physician: _____ Phone # _____

Kan Be Healthy Screening Date: _____Location of Screening: _____

PARENT / LEGAL GUARDIAN AND HOUSEHOLD INFORMATION

Parent Name	Gender	Date of Birth	SSN	Employer	Legal Guardian	Household Member	Emergency Contact	Policy Holder
Address:			**Home Phone:**	**Work Phone:**	**Cell Phone::**			
Parent Name	**Gender**	**Date of Birth**	**SSN**	**Employer**				
Address:			**Home Phone:**	**Work Phone:**	**Cell Phone::**			
Legal Guardian Name (s) (If Not the Parent)			**Daytime Phone**	**Relationship to the Client**				
Emergency Contact Person Not Living with the Client			**Daytime Phone**	**Relationship to the Client**				
Other Household Members Name(s)			**Date of Birth**	**Relationship to the Client**	**FSGC Current Client?**			

Supplemental Determination Benefits: (SSI or SSDI)

___1. Not Applicable; ___2. Eligible and Receiving Payments;

___3. Eligible but not Receiving Payments; ___4. Potentially Eligible (Case not yet Submitted for Determination);

___5. Determined to be Ineligible by Review and Decision. ___6. Determination Decision on Appeal

This information is correct to the best of my knowledge _____ _____

Signature **Date**

FSGC AST USE Only:

MONTHLY HOUSEHOLD INCOME:

Wages, Salary, self-employed (includes Workers' Comp)…….…. _____

Public Assistance (Medicaid) …… _____

Retirement/pension (includes SSI and SSDI). ……..……. _____

Child Support/Alimony…….…. _____

Unemployment insurance……..…. _____

Other……... _____

Number supported by this Income: _____ Sub Total…… _____

Sliding Fee Scale Percentage: _____ Subtract Child Support paid……..... _____

AIMS Referral Source / Code: _____ **Total Income…….……...** _____