

APPLICATION FOR MEDICAL SERVICES

PIMC-58

ASSIGNED PIMC CHART#

DEMOGRAPHIC INFORMATION			
Patient Name: [LAST] [FIRST] [MIDDLE INITIAL]			Patient Sex: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
Other Names Used:	Date of Birth:	Place of Birth:	Social Security#
Address:	Apt #	City:	State: Zipcode:
Community Name:	How long has Child lived at this address?	Is this on a Reservation?	Religion:
Home Phone#:	Cell or Message Phone#:	Which Reservation?	

PATIENT TRIBAL INFORMATION			
Child is: <input type="checkbox"/> Enrolled Tribal Member <input type="checkbox"/> Enrollment is Pending <input type="checkbox"/> A descendent of an Enrolled Member		Tribe Name:	Agency enrolled at:
		Enrollment/Census#:	
Father's Name: [Last] [First] [Middle Initial]		Date of Birth:	Place of Birth:
Father's Tribal Affiliation?	Enrollment/Census#	Date of Death:	Social Security#:
Mother's Maiden Name [Last] [First] [Middle Initial]		Date of Birth:	Place of Birth:
Mother's Tribal Affiliation?	Enrollment/Census#	Date of Death:	Social Security#:

EMPLOYMENT INFORMATION			
Is Mother Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		If No, how long?	Does Mother receive: <input type="checkbox"/> GA <input type="checkbox"/> Other <input type="checkbox"/> AFDC-Foodstamps <input type="checkbox"/> Land Lease
Employer Name:		How long with employer?	Employer Phone#
City	State	Zipcode:	
Mother's Cell Phone#		Alternate Ph #	Email Address:
Is Mother a Student? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		If yes, where? How long?	Does Mother receive? <input type="checkbox"/> Pell Grant <input type="checkbox"/> Tribal Grant <input type="checkbox"/> Scholarship <input type="checkbox"/> Other
Is Father employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		If No, how long?	Does Father receive: <input type="checkbox"/> GA <input type="checkbox"/> Other <input type="checkbox"/> AFDC-Foodstamps <input type="checkbox"/> Land Lease
Father's Employer Name:		How long with employer?	Employer Phone#:
City	State	Zipcode:	
Father's Cell Phone#		Alternate Ph#	Email Address:
Is Father a Student? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		If yes, where? How long?	Does Father receive? <input type="checkbox"/> Pell Grant <input type="checkbox"/> Tribal Grant <input type="checkbox"/> Scholarship <input type="checkbox"/> Other

I certify that the information provided on this form is true to the best of my knowledge.

Signature

Date

Relationship to Parent

Section 1: PERSON WITH CARE RESPONSIBILITY				
Name:		Relationship:		Phone#
Address:	Apt #	City:	State:	Zipcode:
Section 2: SECONDARY CONTACT PERSON				
Name:		Relationship:		Phone#
Address:	Apt #	City:	State:	Zipcode:
Section 3: ALTERNATE RESOURCE INFORMATION				
Do you currently have Medicare? [] Yes [] No			Medicare Number:	
Section 4: ARIZONA AHCCCS PROGRAM				
Are you currently enrolled with the Arizona AHCCCS Program? [] Yes [] No			If yes, please give Health Plan Name:	
If you are not enrolled in the Arizona AHCCCS Program, are you enrolled in another state? [] Yes [] No State: _____			[] American Indian Health Plan	[] Phoenix Health Plan
			[] Mercy Care Plan	[] Health Choice of AZ
			[] Maricopa Health Plan	[] KidsCare
			[] Care First Health Plan	[] Arizona Physicians IPA
			[] Other	
Section 5: PRIVATE INSURANCE				
Are you covered under a Private Insurance Plan? [] Yes [] No			If yes, what is the name of your insurance?	
Who is the primary insured (policy holder)?			Their Social Security Number:	Date of Birth:
Section 6: NEW HEALTH INITIATIVE PROJECTS				
Do you access the internet: [] YES [] NO				
If yes, where?				
[] HOME	[] HEALTH CARE FACILITY	[] MOBILE DEVICE		
[] WORK	[] LIBRARY			
[] SCHOOL	[] TRIBE			
Do you have an email address: [] YES [] NO				
EMAIL ADDRESS:				
Do we have permission to send generic health information to your email address? [] YES [] NO				
What is your preferred method to receive reminders?				
[] PHONE	[] EMAIL	[] MAIL		
ETHNICITY:				
RACE:				
PRIMARY LANGUAGE:		INTREPRETER REQUIRED?		
OTHER LANGUAGE SPOKEN:				
PREFERRED LANGUAGE:				
MIGRANT WORKER: [] YES [] NO If yes, care you a seasonal worker?				
HOMELESS? [] YES [] NO				