accesshealth

Household Composition Form

Head of Household

First Name	Last Name	Date of Birth

Phone Number ☐ Home ☐ Cell ☐ Work

Email

Mailing Address

Apt Number

City/State/Zip

Social Security Number

County

Race (please write one or multiple)

Sex
☐ **M** ☐ **F**

(Office Use Only) Acct No:

Spouse

First Name	Last Name	Date of Birth

Phone Number ☐ Home ☐ Cell ☐ Work

Email

Sex
☐ **M** ☐ **F**

Race (please write one or multiple)

Social Security Number

(Office Use Only) Acct No:

List below everyone who lives with you, and whom you are legally responsible for under the age of 18.

	Name (First, Last, M.I.)	**Social Security Number** (Optional)	**Date of Birth** (MM/DD/YYYY)	**Sex**	**Race**	**Relationship**	**(Office Use Only)** Acct No:
1				☐ M ☐ F			
2				☐ M ☐ F			
3				☐ M ☐ F			
4				☐ M ☐ F			
5				☐ M ☐ F			
6				☐ M ☐ F			
7				☐ M ☐ F			
8				☐ M ☐ F			

List all of your household's income below. *Including: Employment (self or job), Government assistance, child support, unemployment or gift.*

Name of person receiving money	Agency, person, employer who, provides the money	Amount received per month

Ⓐ Do you or any of your family members have medical health insurance? ☐ **Yes** ☐ **No**

Ⓑ **I attest that I have NO PRESCRIPTION DRUG COVERAGE, including Medicare Part D** ☐ **Yes** ☐ **No**

PATIENT SIGNATURE	PRINTED NAME	DATE

RECOGNIZED NCQA PATIENT-CENTERED MEDICAL HOME

COMMUNITY HEALTH CENTER FQHC QUALITY

United Way Greater Houston