

Healthcare Renewal Clinic Screening Questionnaire

Name:		DOB:	Phone:
Tribal affiliation:			
Case #:	PMI #:		County of Residence:
Active on waiver program?		Social Worker Name:	
Social worker phone #:		Need other community resources?	
How did you hear about the clinic?		Do you have an elder advocate?	
<input type="checkbox"/>	Renewing your health insurance	<input type="checkbox"/>	Applying to obtain health insurance
Any other additional information like us to know?			