Lifespan HEALTH
HARDIN COUNTY REGIONAL HEALTH CENTER

PATIENT NAME _____
Head of Household (if different from patient):
_____
DOB_____

Would you like to participate in our federal grant that may help to lower the cost of your healthcare? ☐ Yes ☐ No

Circle your household size	1	2	3	4	5
Circle your household income range	0-$12,140 $11,141-$18,210 $18,211-$24,280 >$24,281	0-$16,460 $16,461-$24,690 $24,691-$32,920 >$32,921	0-$20,780 $20,781-$31,170 $31,170-$41,560 >$41,561	0-$25,100 $25,101-$37,650 $37,651-$50,200 >$50,200	0-$29,420 $29,421-$44,130 $44,130-$58,840 >$58,840

If household number is MORE THAN 5 fill in here

Household _____ Estimated Annual Income_____

Do you have Medicaid/TennCare? ☐ ***Yes*** ☐ ***No***

Are you a Veteran? ☐ Yes ☐No ☐ Choose Not to Answer

Check your race: ☐ White ☐Black ☐Asian ☐American-Indian ☐Multi-Racial ☐ Decline

Are you Hispanic? ☐ Yes ☐No ☐ Choose Not to Answer

Do you think of yourself as:

☐ Straight/Heterosexual ☐ Homosexual ☐ Bisexual ☐ Something Else ☐ Don't Know/Decline

What is your current gender identity? (Check all that apply)

☐ Male ☐ Female ☐ Transgender ☐ Decline to Answer ☐ Other

What sex were you assigned on your birth certificate?

☐ Male ☐ Female ☐ Decline to Answer

Initials (Patient) _____ Initials (LS Employee)_____ Date_____