SCHOOL BASED HEALTH CENTER
A mission of the Methodist Healthcare Ministries

METHODIST HEALTHCARE MINISTRIES
SCHOOL BASED HEALTH CENTER
SOCIAL SERVICES CONTACT FORM

Child's Name: _____ DOB: _____ Age: _____

Gender: ☐ Male ☐ Female Ethnicity: ☐ Caucasian ☐ Hispanic ☐ African-American ☐ other: _____

Child's primary language: _____ School: _____ Grade: ____ Teacher: _____

Parent/Guardian's Name: _____ DOB: _____ Number of people in home: _____

Address: _____ City: _____ Zip: _____

Phone (home): _____ Phone (cell): _____ Phone (work/other): _____

Total family (annual) income $_____

Someone in my home currently receives the following benefits:

☐ Medicaid ☐ CHIP ☐ Food Stamps ☐ TANF ☐ Social Security Disability

☐ Veterans Benefits ☐ SSI ☐ WIC ☐ Unemployment

I am interested in the following services: (please check one or more of the following)

☐ Family Counseling ☐ Education Resources ☐ Community Resources

☐ Medicaid/CHIP ☐ Individual Counseling ☐ Food Stamps/SNAP

☐ TANF (Temporary assistance for needy families)

☐ Other: _____

Additional concerns/needs: _____

_____

I authorize the School Based Social Services Team to contact me for additional information.

Parent/Guardian Signature _____ Date _____

Relationship to Child _____

METHODIST HEALTHCARE MINISTRIES
OF SOUTH TEXAS, INC.
"Serving Humanity to Honor God"

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