

Western North Carolina Community Health Services, Inc.

Medical Enrollment Form

INSTRUCTIONS: Read carefully. Provide **ALL** the information requested. Print clearly in ink. After completing it, return the Enrollment Form by doing any one of the following:

-Handing it to any **Western North Carolina Community Health Services** front desk or security staff member.

-Placing it in the box labeled "Enrollment Forms Only," located outside the main entrance (west side) of the

Western North Carolina Community Health Services, 257 Biltmore Ave., Asheville, NC (available 24/7).

-Sending through U.S. mail to: WNCCHS, PO Box 338, Asheville, NC, 28802.

We will call you to schedule your appointment as appointments become available.

Applicant's First Name: _____

Applicant's Last Name: _____

Applicant's Date of Birth: _____

Applicants' Mailing Address: _____

Applicant's Phone Number (_____) _____

Applicant's e-mail address: _____

Insurance? Yes _____ No _____ (plan name): _____

For Patient Appointment reminder, please check the preferred method below:

Phone Text Email

1) Applicant's preferred language is: English__ Other__ (specify): _____

2) Are you seeking transgender affirming care? Yes _____ No _____

3) Are you seeking Ryan White / HIV care? Yes _____ No _____

4) Are you seeking Hepatitis C care or treatment? Yes _____ No _____

Is there anything else you would like us to know? **(Optional)**

Signature of applicant, guardian or legal representative: _____

Date: _____

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